

Supreme Court, U.S.  
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In The  
**Supreme Court of the United States**

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JOANNE GAGLIANO, PETITIONER,

v.

RELIANCE STANDARD LIFE INS. CO.

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*On Petition for a Writ of Certiorari to the  
United States Court of Appeals for the Fourth Circuit*

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**PETITION FOR A WRIT OF CERTIORARI**

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## QUESTION PRESENTED

In this case, the Fourth Circuit expressly split with its sister circuits on an important question about remedies available under the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, *et seq.* (ERISA).

The Question Presented is:

If employee welfare benefits are terminated in violation of the procedures required by 29 U.S.C. 1133 and regulations promulgated thereunder, does 29 U.S.C. 1132(a)(3) permit a court to reinstate those benefits (or enjoin their termination) until they are terminated in compliance with ERISA?

## RULE 14.1(B) STATEMENT

A list of all parties to the proceeding in the court whose judgment is the subject of this petition is as follows:

Joanne Gagliano, *Plaintiff-Appellee* and *Petitioner*  
Reliance Standard Life Ins. Co., *Defendant-Appellant* and *Respondent*

Mariam, Inc., trading as Darcars Automotive Group, and Unnamed Long Term Disability Ins. Plan for Employees of Darcars, *Defendants*

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Joanne Gagliano ("petitioner") respectfully petitions for a writ of *certiorari* to review the judgment of the United States Court of Appeals for the Fourth Circuit ("Fourth Circuit") in this case.

### OPINIONS BELOW

The opinion of the Fourth Circuit (Pet. App. 1a – 24a) is published at 547 F.3d 230. The order and opinion of the district court granting petitioner's motion for summary judgment and entering judgment in petitioner's favor (Pet. App. 25a – 40a) is unpublished.

### JURISDICTION

The Fourth Circuit's decision reversing and remanding to the district court was entered on November 18, 2008. (Pet. App. 1a – 24a). This Court has jurisdiction under 28 U.S.C. 1254(1).

### STATUTORY PROVISIONS INVOLVED

The following provisions of the Employee Retirement Income Security Act of 1974 ("ERISA") are reproduced at Pet. App. 41a – 43a: 29 U.S.C. 1002(1); 1002(3); 1132(a)(1), 1132(a)(3), and 1133.

### STATEMENT OF THE CASE

1. ERISA is a federal statute that regulates, *inter alia*, "employee welfare benefit plans." 29 U.S.C. 1002(3). The statutory definition of an "employee welfare benefit plan" includes "any plan, fund or program" that provides employees with "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment."

29 U.S.C. 1002(1). As of 2002, 137 million workers, retirees, and their families were covered by such plans.<sup>1</sup>

As this Court has noted, millions of Americans have welfare benefit claims denied each year.<sup>2</sup> Under ERISA, any denial may be challenged in federal court.<sup>3</sup> Yet only a tiny fraction of denials actually results in the commencement of litigation. “According to the Administrative Office of the U.S. Courts, new [ ] ERISA cases [numbered] 9,167 [ ] in 2000 [and] 11,499 [ ] in 2004.”<sup>4</sup>

One reason that many welfare benefit denials do not result in litigation is because of the availability of administrative review.<sup>5</sup> The requirement of “full and

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<sup>1</sup> See Brief of United States Sec’y of Labor as *Amicus Curiae* in Support of Qualchoice’s Petition for *En Banc* Rehearing in *Qualchoice, Inc. v. Rowland*, 367 F.3d 638 (CA6 2004).

<sup>2</sup> See *Met. Life Ins. Co. v. Glenn*, 128 S.Ct. 2343, 2351 (2008) (noting that approximately “1.9 million beneficiaries of ERISA plans have health care claims denied each year”) (citing C. Gresenz *et al.*, A Flood of Litigation? 8 (1999), [http://www.rand.org/pubs/issue\\_papers/2006/IP184.pdf](http://www.rand.org/pubs/issue_papers/2006/IP184.pdf)). Health-care is one important type of welfare benefit. Disability payments are another.

<sup>3</sup> 29 U.S.C. 1132(a)(1)(B) (permitting a plan participant or beneficiary to “recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan”).

<sup>4</sup> Susan M. Mangiero, *ERISA Fiduciaries Beware: Risk Is More Than a Four-Letter Word*, American Bar Association, Probate & Property, Volume 19, No.3, May/June 2005.

<sup>5</sup> Cf. Gresenz *et al.*, A Flood of Litigation? 8 (1999), [http://www.rand.org/pubs/issue\\_papers/2006/IP184.pdf](http://www.rand.org/pubs/issue_papers/2006/IP184.pdf) (noting that in Minnesota’s grievance system, “[a]bout two third of enrollees had their [administrative] complaint settled ‘to their satisfac-

fair" administrative review is codified in ERISA. The relevant section provides:

In accordance with regulations of the Secretary, every employee benefit plan shall -

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. 1133 (entitled "Claims procedure").<sup>6</sup> This petition presents an important question regarding the remedies available to a plaintiff who obtains a judicial determination that section 1133 has been violated.

2. Section 502(a) of ERISA, 29 U.S.C. 1132(a), is entitled "Civil enforcement." This section sets forth the exclusive remedies that are available to a civil litigant under the statute.<sup>7</sup> Its importance can hardly be

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tion"). Of course, there are other reasons why many such denials do not result in litigation. *Cf. id.* (arguing "that approximately 75 percent of disputed denials [in the Medicare context] involve decisions unlikely to provide a strong basis for litigation.").

<sup>6</sup> The relevant regulations are found at 29 C.F.R. 2560.503-1.

<sup>7</sup> See e.g., *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) ("The [ ] carefully integrated civil enforcement provisions found in section 502(a) of the statute as finally enacted

overstated: the extraordinary breadth of subject matter covered by ERISA coupled with an extremely strong preemption doctrine has resulted in the reality that section 1132(a) provides the only means for the remediation of most wrongs suffered in the employee benefits context. As such, it is not surprising that this Court has decided several statutory interpretation cases involving the precise scope of section 1132(a).<sup>8</sup>

One part of section 1132(a)—subsection (1)(A)—sets forth specific penalties for some “procedural” violations of ERISA. 29 U.S.C. 1132(a)(1)(A). Violations of section 1133, however, are not governed by section 1132(a)(1)(A). Instead, civil litigants seeking relief for a violation of section 1133 must rely on section 1132(a)(3) of the statute. Section 1132(a)(3) permits an ERISA plan participant or beneficiary to bring a civil action:

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provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.”); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (“The deliberate care with which ERISA’s civil enforcement remedies were drafted argue strongly for the conclusion that ERISA’s civil enforcement remedies were intended to be exclusive.”).

<sup>8</sup> Counsel of record for petitioner in this case presented oral argument before this Court in the two most recent cases involving 29 U.S.C. 1132(a): *LaRue v. DeWolff, Boberg, & Assoc., Inc.*, 123 S.Ct. 1020 (2008) (interpreting section 1132(a)(2)) and *Sereboff et ux. v. Mid Atlantic Med. Servs., Inc.*, 126 S.Ct. 1869 (2006) (interpreting section 1132(a)(3)). See also *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) (interpreting section 1132(a)(3)); *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993) (interpreting section 1132(a)(3)); *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (interpreting section 1132(a)(2)).

- (A) To enjoin any act or practice which violates any provision of this subchapter, or
- (B) To obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter

\* \* \* \*

29 U.S.C. 1132(a)(3). The question presented by this petition involves the application of section 1132(a)(3) to a section 1133 violation in an important and recurring circumstance. The relevant facts are as follows:

3. In March of 2001, petitioner became a participant in an ERISA-governed welfare plan (the "Plan") insured and administered by respondent. Pet. App. 3a.

In September of 2001, petitioner was diagnosed by her doctor with stress syndrome, anxiety disorder, depression and migraines. Pet. App. 3a; *id.* at 48a (Complaint ¶19). She was advised to stop working until her condition improved. *Id.* In January of 2002, petitioner made a claim for long term disability ("LTD") benefits under the Plan. Pet. App. 49a (Complaint ¶22).<sup>9</sup>

In March of 2002, respondent approved petitioner's claim for LTD benefits. Pet. App. 49a (Complaint ¶23). It did so after petitioner returned a questionnaire it had requested from her to verify that her disability did not result from a pre-existing condition. Pet. App. 3a-4a. This was relevant because the Plan excluded from

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<sup>9</sup> In October of 2001, petitioner filed a claim with respondent for short-term disability ("STD") benefits. Pet. App. 3a. These STD benefits were approved and provided to petitioner; they are not at issue in this case. *Id.*

coverage those disabilities that resulted from a pre-existing condition. Pet. App. 4a.

Petitioner received LTD benefits for several months; then, on September 17, 2002, respondent informed petitioner “that it was terminating the long-term disability benefits because [respondent had concluded that petitioner’s specific medical condition] failed to qualify for disability benefits under the Plan.” Pet. App. 4a (referring to this as the “Initial Termination Letter”); Pet. App. 49a (Complaint ¶¶24, 25). Nowhere in its termination letter did respondent mention any concern that petitioner’s medical condition resulted from a pre-existing condition.

In February of 2003, petitioner commenced this litigation while her administrative appeal was still pending.<sup>10</sup> In her complaint, she asserted several claims, including two under 29 U.S.C. 1132(a)(3). Pet. App. 57a – 60a (Counts III and IV).

In asserting her section 1132(a)(3) claims, petitioner alleged that respondent “breached [its] fiduciary duties to [her] by [ ] fail[ing] to provide [her] with notification [ ] that meets the minimum standards required under ERISA. Pet. App. 58a (Complaint ¶63).<sup>11</sup> As re-

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<sup>10</sup> No one disputes that the relevant administrative procedures were ultimately and properly exhausted by petitioner.

<sup>11</sup> The Fourth Circuit asserted that “[t]he Initial Termination Letter included the requisite notice required by ERISA, 29 U.S.C. 1133.” Pet. App. 4a. This is of no moment, however, because (as explained below) the dispute before the Fourth Circuit involved a *second* termination letter. And the Fourth Circuit squarely held that the second letter violated section 1133. *Id.* at 15a.

lief, she sought—*inter alia*—“an injunction [ ] directing [respondent] to provide all accrued long term disability benefits [and prohibiting respondent] from making any adverse benefit determinations [ ] until such time as they have established a full and fair review of claims.” Pet. App. 58a – 59a.

Petitioner filed a motion for summary judgment which was stayed by the district court because administrative review was unfinished. Pet. App. 5a. The district court ordered respondent “to conduct an Independent Medical Examination (‘IME’) and to ‘complete the administrative review process and render a final decision on [Gagliano’s] administrative appeal.’” *Id.* at 6a (quoting district court).

The IME confirmed that petitioner was correct in challenging the validity of the termination. Pet. App. 6a. Nonetheless, respondent sent petitioner a letter dated September 9, 2003 purporting to be its final claim decision. *Id.* (referring to this as the “Second Termination Letter”). For the first time (in this new letter), respondent relied on the Pre-Existing Conditions Limitation as the basis for termination of benefits. *Id.* Petitioner filed a new summary judgment motion, again arguing that respondent failed to “even minimally comply with ERISA.” *Id.* at 7a.

4. The district court granted summary judgment for petitioner. Pet. App. 39a. In so doing, “[t]he district court held that [respondent] did not comply with the notice requirements of ERISA when it denied [petitioner’s] claim in the Second Termination Letter on a different basis than in the Initial Termination Letter.” Pet. App. 8a. According to the district court, “this ac-

tion violated the notice requirements under ERISA, particularly 29 U.S.C. § 1133 and its underlying regulations." Pet. App. 8a.

The district court then addressed the issue of how to remedy the violation of section 1133. As the Fourth Circuit explained:

The district court determined that the proper remedy for the violation of ERISA's procedural requirements was to award the payment of disability benefits to [petitioner] rather than to remand the case to the plan administrator for an administrative review on [*sic*] the Pre-Existing Conditions Limitation issue.

*Id.* Respondent appealed to the Fourth Circuit.

5. The court of appeals began by affirming the district court's holding that respondent had violated 29 U.S.C. 1133. Pet. App. 15a (concluding that "the district court did not err in determining 'that [respondent] failed to comply with the notice requirements of ERISA [ ] and affirm[ing] the district court's judgment in that regard").

Next, the court of appeals made clear that the substantive question of whether petitioner qualified for benefits under the Plan was *not* before the court:

Even though [respondent] argues [ ] that the record proves the Pre-Existing Conditions Limitation applies, and thus we should enter judgment for [it], this argument is, at best, premature. Due to the failure of [respondent] to comply with ERISA notice requirements, [petitioner] was denied her right to make an administrative record on the Pre-Existing

Conditions Limitation issue as well as other rights set forth in 29 C.F.R. § 2560-503-1(h).

Pet. App. 21a.

Finally, the Fourth Circuit turned to the issue of what remedy was available to petitioner in light of the section 1133 violation (*i.e.*, the question presented). Respondent argued that “a substantive remedy is inappropriate for a procedural ERISA violation and the correct remedy is a remand to the plan administrator for a ‘full and fair review.’” Pet. App. 17a. The court of appeals agreed with respondent. *Id.* at 21a. It reversed the district court on this issue and “remand[ed] the case to the plan administrator for a full and fair review regarding the basis for denial of benefits in the Second Termination Letter.” *Id.* at 21a – 22a.<sup>12</sup> In so doing, the Fourth Circuit expressly recognized that it was creating a circuit split. *Id.* at 22a – 23a.

This petition followed.

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<sup>12</sup> Respondent also argued, and the court of appeals agreed, that the district court erred in holding that respondent waived its right to rely on the pre-existing condition exclusion. Pet. App. 17a (agreeing with respondent that “state law claims for waiver and estoppel are pre-empted by ERISA,” [and] that the [district] court [ ] applied the concept of waiver to estop [respondent] from asserting the Pre-Existing Conditions Limitation.”). Petitioner does not seek further review on this waiver/estoppel question.

## REASONS FOR GRANTING THE WRIT

### I. AS THE FOURTH CIRCUIT ACKNOWLEDGED, THE CIRCUITS ARE DIVIDED OVER THE QUESTION PRESENTED

The decision below creates a square conflict with the Third, Sixth, Seventh, and Ninth Circuits. In resolving the question presented, the court of appeals held as follows:

Even though [respondent] failed to provide [petitioner] with the proper [ ] notice required by ERISA \* \* \*, that procedural violation [of § 1133] cannot afford [petitioner] a substantive remedy if she has no entitlement to benefits under the terms of the Plan. In cases where there is a procedural ERISA violation, we have recognized the appropriate remedy is to remand the matter [ ] so that a "full and fair review" can be accomplished.

Pet. App. 21a (footnote omitted).

The Fourth Circuit expressly acknowledged that it was creating a circuit split. Pet. App. 22a ("The district court's reliance on the Sixth Circuit's decision in *Wenner* was misplaced, both because it is contrary to the law of this circuit and because that decision's rationale is flawed."). In *Wenner*, the Sixth Circuit held that a court may reinstate benefits that have been terminated in violation of section 1133. In the words of the Sixth Circuit:

When an initial grant of benefits has been terminated in violation of § 1133, the benefits have "*never been properly revoked*." Thus, [the] procedural violation is not the reason that [the]

benefits commenced, but [it] is the reason that they should continue until a decision regarding the potential revocation of \* \* \* benefits has been properly determined in compliance with the plan's provisions."

*Wenner v. Sun Life Assurance Co.*, 482 F.3d 878, 883 (CA6 2007) (quotation and citation omitted) (emphasis in original).

As expressly noted in *Wenner*, the law of the Seventh Circuit is identical to that of the Sixth Circuit. *See Wenner*, 482 F.3d at 883-84 (adopting the reasoning of, and citing, *Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3d 621 (CA7 2005)). In *Schneider*, the Seventh Circuit held that:

prior to the termination of her benefits by improper procedures, the status quo was that Ms. Schnieder was receiving long-term disability benefits from the Plan. The appropriate remedy is an order vacating the termination of her benefits and directing [the fiduciary] to reinstate retroactively the benefits. [T]he decision to terminate Ms. Schneider's long-term disability benefits was not accompanied by the proper procedural protections, but it was not necessarily wrong. [The fiduciary] is free to revisit Ms. Schneider's eligibility for benefits.

*Schneider*, 422 F.3d at 630 (concluding that reinstatement of benefits is the appropriate way to "restor[e] the status quo prior to the procedural misstep").

The Third Circuit has resolved the question presented consistently with the Sixth and Seventh Circuits. *See, e.g., Grossmuller v. Int'l. Union et al.*, 715

F.2d 852 (CA3 1983) (finding a violation of section 1133 and holding that “[u]pon remand, the district court should enter an order prohibiting the plan from terminating Grossmuller’s benefits \* \* \* until Grossmuller has received full and fair review.”). And the Ninth Circuit has similarly rejected the Fourth Circuit’s position. *Pannebecker v. Liberty Life Assurance Co.*, 542 F.3d 1213, 1221 (CA9 2008) (“The district court should have awarded [plaintiff] benefits from the time of [defendant’s] improper denial [ ] until the company’s decision [ ] to decline to alter its benefits determination.”).

According to the Fourth Circuit: “[t]he only exception to [its] rule would be where the record establishes that the plan administrator’s denial of the claim was an abuse of discretion as a matter of law.” Pet. App. 22a. *See id.* (noting that the exception did not apply in this case because “the record reflects, at minimum, a colorable claim that the Pre-Existing Conditions Limitation applies”). In rejecting *that precise argument*, the Ninth Circuit recently explained:

[W]hether the administrator abused its discretion because the decision was substantively arbitrary or capricious, *or because it failed to comply with required procedures*, benefits may still be reinstated if the claimant would have continued receiving benefits absent the administrator’s [violation of ERISA].

*Pannebecker*, 542 F.3d at 1221 (emphasis added).

Put simply, there is a clear split involving five courts of appeals over the question presented. In light of the importance of the question, see Section II below, there can be little doubt that this petition satisfies the

Court's criteria for *certiorari*. Sup. Ct. Rule 10(a) (compelling reasons for *certiorari* include the fact that "a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter").

## II. THE QUESTION PRESENTED IS EXTREMELY IMPORTANT

Millions of Americans are covered by employer-sponsored disability insurance. According to the United States Department of Labor, Bureau of Labor Statistics, "short and long-term disability benefits were available [in 2004] to 39 and 30 percent of workers, respectively, and nearly all participated."<sup>13</sup>

As with all welfare benefits governed by ERISA, the system of resolving disability claim disputes would be untenable without the administrative review scheme codified in 29 U.S.C. 1133.<sup>14</sup> In the words of one court

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<sup>13</sup> United States Department of Labor, Bureau of Labor Statistics, National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2004 at 1, available at <http://www.bls.gov/ncs/ebs/sp/ebsm0002.pdf>. See also November 5, 1999 Letter from Barbara D. Bovbjerg, Associate Director, Education, Workforce, and Income Security Issues for the United States General Accounting Office to the Honorable Robert E. Andrews, Ranking Minority Member of the Subcommittee on Employer-Employee Relations Committee on Education and the Workforce of the United States House of Representatives, available at <http://archive.gao.gov/pdf/163015.pdf> (noting that, according to 1996-97 data, approximately 36% and 26% of all employees in the private sector had STD and LTD insurance respectively).

<sup>14</sup> As the Fourth Circuit itself has noted, proper administrative review is needed to "vindicate 'Congress's apparent intent in mandating internal claims procedures \* \* \* which was to minimize

of appeals, “[i]n an ERISA benefit denial case, trial is usually not an option: in a very real sense, the district court sits more as an appellate tribunal than as a trial court.”<sup>15</sup> This Court recently confirmed as much when it refused to “overturn *Firestone* by adopting a rule that in practice could bring about near universal review by judges *de novo*—i.e., without deference—of the lion’s share of ERISA plan claims denials.”<sup>16</sup>

Because disability claims are often wrongfully denied or terminated, the question presented affects an extraordinary number of potential claimants.<sup>17</sup> And the question is of manifest importance because disability benefit claimants are often unable to work.<sup>18</sup> Being able to eventually recover back payments with interest is

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the number of frivolous lawsuits; promote consistent treatment of claims; provide a non-adversarial dispute resolution process; and decrease the cost and time of claim settlement.” *Gayle v. United Parcel Service*, 401 F.3d 222, 229 (CA4 2005) (citation omitted).

<sup>15</sup> *Leahy v. Raytheon Co.*, 315 F.3d 11, 18 (CA1 2002).

<sup>16</sup> *Met. Life Ins. Co. v. Glenn*, 128 S.Ct. 2343, 2350 (2008).

<sup>17</sup> See, e.g., Maine Bureau of Insurance Press Release, *Landmark Multi-State Settlement Takes Effect; National Remedy Grants Claims Review for Thousands* (Dec. 21, 2004) available at [http://www.state.me.us.pfr/press/ins\\_UnumProvident\\_settlement.htm](http://www.state.me.us.pfr/press/ins_UnumProvident_settlement.htm) (describing a landmark agreement in which the largest disability insurer in the United States agreed (i) to pay a \$140 million settlement, (ii) to pay a \$15 million penalty, and (iii) to reexamine more than 200,000 disability benefit claims).

<sup>18</sup> See, e.g., United States Department of Labor, Office of Disability Employment Policy Fact Sheet of January 2009, available at <http://www.dol.gov/odep/> (noting that “the unemployment rate for those with disabilities was 13.2 percent”).

hardly comforting to those individuals who are completely reliant on continued benefits in order to pay for basic living expenses. As one court of appeals has noted, "the costs of delay are [very] high[ ] for claimants, who may need disability benefits to buy their daily bread."<sup>19</sup>

To be fair, however, the question presented is also of extraordinary importance to fiduciaries. Having to continue paying improperly granted—or no longer owed—disability benefits during the pendency of the administrative process means that fiduciaries will be forced to rely on recoupment provisions (*i.e.*, seeking *ex post* repayment) in order to recover monies received by claimants to which there was no legitimate entitlement. And the reasoning of many courts who have adopted the majority position appears to foreclose such recoupment if the fiduciary has failed to comply with the procedures required by section 1133.<sup>20</sup>

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<sup>19</sup> *Gilbertson v. Allied Signal, Inc. et al.*, 328 F.3d 625, 635 36 (CA10 2003).

<sup>20</sup> See, e.g., *Pannebecker*, 542 F.3d at 1215, 1221-22 (upholding a plan's most recent decision to deny benefits as proper *but also holding* that claimant was entitled to retroactive benefits for the period between plan's procedurally improper denial and plan's procedurally and substantively proper denial of benefits); *Laucks v. Provident Cos.*, No. 1CV971507, 1999 WL 33320463 at \*9 (M.D. Pa., October 29, 1999) (unpublished) (holding, after a trial, that the claimant was not eligible for disability benefits but nonetheless awarding retroactive benefits from the point at which the fiduciary terminated benefits until the date of the court's order because the termination did not comply with the procedures of section 1133).

### III. IMMEDIATE REVIEW IS NEEDED.

As is readily apparent, the question presented was squarely addressed and outcome determinative in this case. As explained above, the question is extremely important and frequently recurring. And, as the Fourth Circuit expressly noted, the question is the subject of a clear split among the courts of appeals. Although this 4-1 circuit split was created by the Fourth Circuit in this case, immediate review by this Court is necessary.<sup>21</sup> This is true for two reasons.

First, there is a strong need for national uniformity regarding the question presented given its importance and the underlying purpose of ERISA. As this Court noted over two decades ago:

An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations \* \* \* \* The most efficient way to meet these responsibilities is to estab-

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<sup>21</sup> Two of the most recent ERISA cases in which this Court granted *certiorari* similarly involved newly created circuit splits on important questions of statutory interpretation. *LaRue v. DeWolff, Boberg, & Assoc., Inc.*, 128 S.Ct. 1020 (2008) (where the Fourth Circuit created a split with the Third, Fifth, Sixth, and Seventh Circuits on a question involving 29 U.S.C. 1132(a)(2)) and *Beck v. PACE Int'l. Union*, 127 S.Ct. 2310 (2007) (where the Ninth Circuit created a split with the Third and Sixth Circuits on a question involving 29 U.S.C. 1341(b)(3)(A)). In both *LaRue* and *Beck*, the United States participated as *amicus curiae* at the merits stage. In both cases, the United States recommended that the Court grant *certiorari* after the views of the Solicitor General had been requested. Petitioner respectfully submits that the views of the United States would be helpful in this case.

lish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States.

*Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9, (1987).

Second, further percolation is likely to proceed slowly while yielding little—if any—benefit. Percolation is likely to proceed slowly because lower courts regularly (i) find a violation of 29 U.S.C. 1133, (ii) remand to the plan administrator, and (iii) deny plaintiffs request for reinstatement of benefits without any discussion of whether (a) the court is exercising its discretion or (b) the court believes that reinstatement is an unavailable remedy under ERISA.<sup>22</sup> In light of this

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<sup>22</sup> See, e.g., *Urso v. Prudential Ins. Co. of America*, 2004 U.S. Dist. LEXIS 23930 (D.N.H. 2004) (finding violation of 29 C.F.R. 2560.503-1(i)(3), which requires that administrator notify claimant of its decision on an appeal of denial of disability benefits claim within 45 days of receiving the request for review, but determining that “remand [ ] to the administrator to reconsider the beneficiary’s claim \* \* \* appears to be the appropriate remedy in this case” and noting that “[a] procedural irregularity under the ERISA regulations does not entitle a beneficiary to an award of benefits”) (citations omitted); *Mullin v. Whirlpool Corporation, et al.*, 2007 U.S. Dist. LEXIS 12065 (N.D. Iowa 2007) (finding violation of, *inter alia*, 29 C.F.R. 2560.503-1(h)(3)(i), which requires 180 days to appeal an adverse benefit termination, and 29 C.F.R. 2560.503-1(h)(3)(i), which requires review by an *independent* medical professional, but denying plaintiff’s motion for summary judgment and, instead, remanding to the “Claim Appeal Fiduciary”); *Abate*

common practice, resolution of the question presented by a court of appeals will only happen in a small subset of cases. Because the question is regularly outcome determinative, yet unlikely to be squarely addressed by the courts of appeals, this case is an ideal vehicle for its resolution.

At the same time, percolation is unlikely to be productive because the competing arguments have already been well developed. The majority position is that "equitable relief" permits preservation of the status quo. See, e.g., *Schnieder*, 422 F.3d at 629. If a determination is made that a claimant is entitled to benefits, she has a right to continue receiving such benefits until the point at which it is determined—in compliance with ERISA—that she was not (or is no longer) entitled.<sup>23</sup> The minority position is that only the terms of a plan are relevant in determining whether a claimant is en-

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*v. Hartford, Equiva Services, LLC et al.*, 471 F.Supp. 2d 724 (E.D.Tex. 2006) (finding fiduciary's "decision to discontinue [ ] benefits was based upon incomplete administrative record," remanding to the plan administrator, and denying plaintiff's motion for summary judgment "as premature in view of the remand").

<sup>23</sup> Any concern that the claimant will have received benefits to which she was not entitled under the plan could be addressed through the inclusion and enforcement of plan recoupment provisions. In other words, a plan fiduciary can seek repayment of any monies paid in error *once the granted benefits are terminated in compliance with the statute*. Whether such recoupment will be permitted, however, turns on the *theory* of benefit restatement for section 1133 violations. See note 20, *supra* (explaining that some courts who have adopted the minority position seem to foreclose the possibility of recoupment). This is yet another reason why immediate guidance is needed from this Court.

titled to benefits; either she is entitled or not.<sup>24</sup> If she was mistakenly granted benefits (or if she is no longer eligible), then there is nothing about the status quo to which she has a right to preserve. If she ultimately succeeds in proving eligibility, she will be entitled to get back payments and interest.<sup>25</sup>

Put simply, immediate guidance is needed from this Court regarding the proper resolution of the question presented. Without such guidance, the circuit division and lower court confusion regarding this important question of statutory construction will continue unabated.

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<sup>24</sup> This is the position that was taken not only by the Fourth Circuit in this case but also by the dissenting member of the Sixth Circuit panel in *Wenner v. Sun Life Assurance Co.*, 482 F.3d 878 (CA6 2007). Pet. App. 22a – 23a (“[T]here is no statutory basis in ERISA for the payment of benefits not otherwise required by the plan as a penalty for violating procedural requirements.”) (quoting *Wenner*, 482 F.3d at 884) (Rogers, J., dissenting).

<sup>25</sup> *Id.* 23a (arguing that, under the majority view, a plaintiff “receives a windfall [ ] if after proper procedures it is determined that the plaintiff was not entitled to the benefits that the administrator terminated with flawed procedures”).

### CONCLUSION

For all the reasons discussed above, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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FEBRUARY 2009

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**APPENDIX**

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APPENDIX A

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PUBLISHED

UNITED STATES COURT OF APPEALS  
FOR THE FOURTH CIRCUIT

No. 07-1901

[Filed November 18, 2008]

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JOANNE GAGLIANO,	)
<i>Plaintiff-Appellee,</i>	)
	)
v.	)
	)
RELIANCE STANDARD LIFE	)
INSURANCE COMPANY,	)
<i>Defendant-Appellant,</i>	)
	)
and	)
	)
MARIAM, INCORPORATED, trading as	)
Darcars Automotive Group;	)
UNNAMED LONG TERM DISABILITY	)
INSURANCE PLAN FOR EMPLOYEES OF	)
DARCARS,	)
<i>Defendants.</i>	)

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Appeal from the United States District Court  
for the Eastern District of Virginia, at Alexandria.  
Leonie M. Brinkema, District Judge.

(1:03-cv-00160-LMB)

Argued: September 25, 2008

Decided: November 18, 2008

Before NIEMEYER and AGEE, Circuit Judges,  
and Richard L. VOORHEES,  
United States District Judge  
for the Western District of North Carolina, sitting by  
designation.

Affirmed in part, reversed in part, and remanded by  
published opinion. Judge Agee wrote the opinion, in  
which Judge Niemeyer and Judge Voorhees joined.

### **COUNSEL**

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Pennsylvania, for Appellant. Karl William Pilger,  
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Appellee.

### **OPINION**

AGEE, Circuit Judge:

Reliance Standard Life Insurance Company  
("Reliance") appeals from the judgment of the United  
States District Court for the Eastern District of  
Virginia at Alexandria, in favor of Joanne Gagliano  
("Gagliano"). The district court held that Gagliano was  
entitled to benefits under a policy of disability  
insurance issued by Reliance, based on noncompliance  
with certain procedural requirements of the Employee

Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* For the following reasons, we affirm in part and reverse in part the judgment of the district court. We hold that, although Reliance violated ERISA, the proper remedy is to remand the case to the plan administrator for a full and fair review.

## I.

On March 13, 2001, Gagliano enrolled in an employee welfare benefit plan ("the Plan") offered by her employer, Mariam, Incorporated ("Darcars"). The Plan was insured by Reliance, also the plan administrator. In September, 2001, Gagliano, a finance manager for her employer, "was diagnosed with stress syndrome, anxiety disorder, depression and migraine by her treating physician and was advised to discontinue working at Darcars until her condition improved." *Gagliano v. Reliance Standard Life Ins. Co.*, No. 1:03-cv-160, slip op. at 2 (E.D. Va. Aug. 22, 2007). In October, 2001, Gagliano filed a claim with Reliance for short-term disability benefits based on these mental health problems. *Id.* Reliance approved her claim for short-term benefits, and began reviewing her claim for long-term disability benefits.<sup>1</sup> In that process, Reliance requested that Gagliano complete a Pre-Existing Conditions Questionnaire to verify that the Pre-Existing Conditions Limitation did not apply to her claim.<sup>2</sup> Gagliano completed the Questionnaire

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<sup>1</sup> Gagliano received the short-term disability benefits provided under the Plan. The issue in this case relates only to the termination of Gagliano's long-term disability benefits.

<sup>2</sup> The Pre-Existing Conditions Limitation under the Plan excludes from coverage any claims that arose from a pre-existing condition,

and Reliance approved her claim for long-term disability benefits in March, 2002.<sup>3</sup>

Upon a review of Gagliano's medical records, Reliance determined "that the medical records provided do not support a physical or mental condition, which would prevent you from performing your occupation as a finance manager in the general economy." A covered disability under the Plan required that "an Insured cannot perform the material duties of his/her regular occupation." By a letter dated September 17, 2002 (the "Initial Termination Letter"), Reliance informed Gagliano that it was terminating the long-term disability benefits because she was not restricted from returning to work and thus failed to qualify for disability benefits under the Plan.

The Initial Termination Letter included the requisite notice required by ERISA, 29 U.S.C. § 1133, informing Gagliano of her right to appeal the denial of her claim. Gagliano did timely appeal the denial of benefits in the Initial Termination Letter to the plan administrator, but during the administrative review process she filed the present civil action in the district court on February 5, 2003 before the review was completed.

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defined as "any Sickness or Injury for which the Insured received medical treatment, consultation, care or services . . . during the three months immediately prior to the Insured's effective date of insurance." March 13, 2001 was Gagliano's effective date of insurance.

<sup>3</sup> Although long-term, these benefits are limited under the Plan to payments for twenty-four months.

Gagliano's complaint named Darcars, the Plan, and Reliance as defendants and alleged various breaches by them of obligations under the Plan and ERISA. Gagliano alleged that she "has met and currently meets all requirements for the receipt of long term disability benefits from Reliance," including an inability to return to work. Gagliano claimed that Reliance had abused its authority in failing to recognize that she met the Plan requirements, had failed to articulate a rational basis for the determination in the Initial Termination Letter, and had relied on an incomplete record. Gagliano sought an injunction directing payment to her of the long-term disability benefits and preventing any adverse benefit determinations against her "until such time as they have established a full and fair review of claims and adverse benefit determinations, as well as establishing and following reasonable claim procedures." In the alternative, Gagliano requested monetary damages, pre-judgment interest, and attorney's fees.<sup>4</sup>

During summary judgment proceedings, the district court determined that the record was not complete because the administrative review of Gagliano's appeal from the Initial Termination Letter was unfinished. By order dated July 11, 2003 ("the July 11 Order"), the court stayed Gagliano's pending motion for summary judgment and directed Reliance

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<sup>4</sup> Gagliano's employer, Mariam, Incorporated, trading as Darcars Automotive Group, is a Maryland corporation that operates a group of car dealerships in the Washington, D.C. area. Darcars was a defendant in the initial suit filed by Gagliano. All claims against Darcars were resolved and are not before the Court in this appeal.

to conduct an Independent Medical Examination ("IME") and to "complete the administrative review process and render a final decision on [Gagliano's] administrative appeal."

The IME established that Gagliano was suffering from a covered disability which entitled her to benefits under the Plan because her mental health condition prevented her from working in her regular occupation. *Gagliano*, slip op. at 5. Reliance then sent Gagliano a letter dated September 9, 2003 (the "Second Termination Letter"), purporting to be its final decision on her claim pursuant to the July 11 Order. However, the Second Termination Letter did not address the basis for denial of benefits in the Initial Termination Letter or the results of the IME, which were the subjects of the pending administrative review. Instead, for the first time, Reliance cited the Pre-Existing Conditions Limitation under the Plan as the basis to deny the disability benefits. Reliance informed Gagliano in the Second Termination Letter that her medical records presented for review showed she had received treatment for "stress syndrome/ anxiety disorder" within three months of March 13, 2001, the effective date of her insurance under the Plan. Since Gagliano "received medical care for a condition(s) which caused, contributed to or resulted in her eventual Total Disability due to psychiatric illness during the three months prior to her effective date of coverage, her claim must be refused under the Policy's Pre-Existing Conditions Limitation."

The Second Termination Letter did not advise Gagliano that she was entitled to an administrative appeal, or otherwise reference her rights under ERISA. Reliance further stated in the Second

Termination Letter that “our claim decision is now final in accordance with the court’s July 11, 2003 ruling . . . . [H]owever, . . . we would be happy to consider any additional information . . . if the court thinks further review by [Reliance] would be warranted in the present case.”

Gagliano again moved for summary judgment, arguing that Reliance improperly denied benefits in the Second Termination Letter on entirely new grounds and its “failure to even minimally comply with ERISA.” Reliance responded that it was Gagliano’s lack of complete disclosure on the Questionnaire which prevented it from asserting the Pre-Existing Conditions Limitation at an earlier time. In light of this argument, the district court denied Gagliano’s motion for summary judgment and *sua sponte* reconsidered and granted Reliance’s previously denied motion for summary judgment by order of October 20, 2003. Gagliano timely filed a motion for rehearing and reconsideration and relief from that judgment. For reasons not adequately explained in the record, this motion lay dormant in the district court until Gagliano renewed the motion in January, 2007. The district court directed the parties to re-file motions for summary judgment. By opinion and order dated August 22, 2007, the court awarded summary judgment to Gagliano.

The district court held that Reliance did not comply with the notice requirements of ERISA when it denied Gagliano’s claim in the Second Termination Letter on a different basis than in the Initial Termination Letter. By doing so, Reliance did not accord Gagliano the opportunity for administrative appeal of its decision to terminate benefits based on the Pre-

Existing Conditions Limitation. *Gagliano*, slip op. at 9-10. The district court held this action violated the notice requirements under ERISA, particularly 29 U.S.C. § 1133 and its underlying regulations.

The district court then determined that the proper remedy for the violation of ERISA's procedural requirements was to award the payment of disability benefits to Gagliano rather than to remand the case to the plan administrator for an administrative review on the Pre-Existing Conditions Limitation issue. The court opined that Reliance "negligently misse[d] available facts" by failing to cite the Pre-Existing Conditions Limitation in the Initial Termination Letter, and that Reliance, "given the equitable nature of the protections found in ERISA," should not be allowed to benefit by this "mistake" with a "second chance to litigate [the] issue." *Gagliano*, slip op. at 15. The court vacated its earlier award of judgment to Reliance and ordered Reliance to pay Gagliano the remaining disability benefits because "[i]t was Reliance's failure to evaluate that evidence in its initial processing of Gagliano's claims that led to this litigation." *Id.*

Reliance timely brings this appeal of the district court's judgment. This Court has jurisdiction over this appeal pursuant to 28 U.S.C. § 1291.

## II.

Reliance argues four issues on appeal. First, Reliance asserts no procedural violation of ERISA occurred, therefore the district court could not award judgment to Gagliano. Next, Reliance contends that the district court erred when it held that Reliance

could not assert the Pre-Existing Conditions Limitation because Reliance was “negligent” in failing to properly recognize that defense before assigning a different basis for termination of benefits in the Initial Termination Letter. Third, Reliance argues that, even if there was a procedural ERISA violation, the district court erred because the proper remedy was a remand of the case to the plan administrator for an administrative review of the termination basis in the Second Termination Letter. Lastly, Reliance posits that the district court erroneously reconsidered its earlier award of summary judgment to Reliance because there was no basis to do so.

On appeal from the district court, we review *de novo* the court’s conclusions of law. *Provident Life & Accident Ins. Co. v. Cohen*, 423 F.3d 413, 418 (4th Cir. 2005). We also review *de novo* a district court’s ruling on a motion for summary judgment. *Eckelberry v. Reliastar Life Ins. Co.*, 469 F.3d 340, 343 (4th Cir. 2006).

#### A. ERISA Violation

ERISA requires that every employee benefit plan “provide adequate notice in writing to any participant or beneficiary whose claim for benefits . . . has been denied, setting forth the specific reasons for such denial.” 29 U.S.C. § 1133 (2008). The Plan must further “afford a reasonable opportunity to any participant whose claim for benefits has been denied a full and fair review by the appropriate named fiduciary of the decision denying the claim.” *Id.* The regulations implementing these statutory requirements provide that a “full and fair review” includes the opportunity for the claimant to appeal the

adverse benefits determination and to submit written comments or records. The claimant must also be given reasonable access to documents relevant to her claim, and the resulting review must take into account all relevant information submitted by the claimant. 29 C.F.R. § 2560.503-1(h)(1-2) (2008).

The purpose of the ERISA mandated appeal process is an important one. That process enables a claimant who is denied benefits to have an impartial administrative review, but also make an administrative record for a court review if that later occurs. *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 236-37 (4th Cir. 1997). Without this opportunity to make a meaningful administrative record, courts could not properly perform the task of reviewing such claims, a specific function entrusted to the courts by ERISA. Moreover, plan participants would be denied their statutory rights. *Id.* Procedural guidelines are at the foundation of ERISA and “full and fair review must be construed . . . to protect a plan participant from arbitrary or unprincipled decision-making.” *Weaver v. Phoenix Home Life Mut. Ins. Co.*, 990 F.2d 154, 157 (4th Cir. 1993) (quoting *Grossmuller v. UAW Local 813*, 715 F.2d 853, 857 (3d Cir. 1983)).

The district court’s award of summary judgment to Gagliano was based on the threshold determination that “[i]t is uncontested that Reliance failed to comply with the notice requirements of ERISA, because it never afforded Gagliano the opportunity to appeal its decision to terminate her benefits on the new ground of the pre-existing condition exclusion.” *Gagliano*, slip op. at 9. On appeal, Reliance argues that holding is contested and contends no ERISA violation, procedural

or otherwise, occurred and thus Gagliano was not entitled to judgment.

Reliance contends that no ERISA violation occurred by virtue of the claim resolution in the Second Termination Letter because (1) ERISA "only requires the inclusion of appeal language in an initial denial letter," (Br. 27); (2) the July 11 Order required a "final decision on plaintiff's administrative appeal" and therefore took precedence over any ERISA statutory requirement; and (3) assuming a technical ERISA violation occurred, Reliance nonetheless "substantially complied with its obligations under ERISA, and that is all that is required." (Br. 29). For the following reasons, we disagree with Reliance.

### 1. Initial Denial

The Initial Termination Letter denied Gagliano benefits because "the records do not include information to suggest that you are restricted from returning to work." It is from this determination that she noted her administrative appeal and, that appeal not having been resolved when Gagliano filed her complaint in the district court, was the subject matter to which the July 11 Order was directed.

However, the grounds Reliance cited to deny Gagliano's claim for disability benefits in the Second Termination Letter were completely different from those in the Initial Termination Letter. In fact, Reliance never addressed in the Second Termination Letter the grounds for denial in the Initial Termination Letter. Instead, the Second Termination Letter cited a wholly new basis to deny Gagliano's claim, the Plan's Pre-existing Conditions Limitation.

Assuming, but not deciding, that the notice and appeal requirements, as implemented by the ERISA regulations, 29 C.F.R. § 2560.503-1(h) *et seq.*, apply only to an "initial" denial, it is clear the denial of benefits rationale in the Second Termination Letter was an initial denial on the basis of the Pre-Existing Conditions provision. As such, Gagliano was statutorily entitled to the ERISA appeals notice as to the new basis for denying her claim and Reliance failed to provide that notice. Reliance thus cannot avoid the determination of an ERISA violation under 29 U.S.C. § 1133, for failure to provide the required appeal information in the Second Termination Letter, because that letter was an initial denial as to the Pre-Existing Conditions Limitation.

## 2. The July 11 Order

Reliance next contends that if an ERISA appeals notice to Gagliano was required, based on the new grounds in the Second Termination Letter, it was relieved of that requirement by the directory language of the July 11 Order, to "render a final decision on plaintiff's administrative appeal."

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As just noted above, however, the Second Termination Letter did not address the subject matter of Gagliano's administrative appeal (the reason for denial of benefits in the Initial Termination Letter), but made a "final decision" to deny benefits on a wholly new ground (pre-existing condition). Nothing in the July 11 Order limited Reliance's statutory duty to comply with the mandates of ERISA while making a "final decision," even though the Second Termination Letter effectively made an initial decision on new grounds. Moreover, we are aware of no provision in

ERISA or otherwise, which would permit the district court, by judicial fiat, to abrogate and nullify a claimant's validly existing statutory entitlements under ERISA.

The force of such a rule, making the party act on pain of certain punishment regardless of the validity of the order violated or the court's jurisdiction to enter it as determined finally upon review, would be not only to compel submission. It would be also in practical effect for many cases to terminate the litigation, foreclosing the substantive rights involved without any possibility for their effective appellate review and determination.

*United States v. United Mine Workers of America*, 330 U.S. 258, 351-52 (1947).

Putting aside the frailty of Reliance's proposed judicial limitation of a claimant's statutory rights, it is evident from the plain language of the July 11 Order that the district court did not direct Reliance to ignore Gagliano's ERISA rights during the process of an administrative review or purport to grant Reliance the authority to do so.

### 3. Substantial Compliance

Citing *Ellis v. Metropolitan Life Insurance Co.*, 126 F.3d 228 (4th Cir. 1997), for the proposition that "substantial" compliance with the spirit of the regulation will suffice, for "not all procedural defects will invalidate a plan administrator's decision," *id.* at 235 (quoting *Brogan v. Holland*, 105 F.3d 158, 165 (4th Cir. 1997)), Reliance contends the language of the

Second Termination Letter was in substantial compliance with the ERISA requirement for appeal notice to a claimant. Specifically, Reliance posits that the closing sentence of the Second Termination Letter, "we would be happy to consider any additional information your client wishes [Reliance] to review" effectuated substantial compliance with ERISA. We disagree.

Reliance does not challenge the validity of the regulations at 29 C.F.R. § 2560.503-1 implementing the notice provision of 29 U.S.C. § 1133. Those regulations specify the claims procedures necessary to meet the ERISA requirements for a "full and fair review," including, but not limited to the following:

[T]he claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures . . . (ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

29 C.F.R. § 2560.503-1(h)(2)(ii)-(iv) (2008); *see also* § 2560.503-1(h)(4). Reliance's offer to "consider any additional information" is not remotely close to any concept of substantial compliance under the regulations and is further evidenced by the absence of any case authority cited by Reliance to support its argument. Thus, the contention that Reliance substantially complied with the ERISA notice requirements is without merit.

Accordingly, we conclude the district court did not err in determining "that Reliance failed to comply with the notice requirements of ERISA," *Gagliano*, slip op. at 9, and affirm the district court's judgment in that regard.

### B. Remedy

"Having concluded that Reliance violated ERISA," the district court properly reasoned that "the remaining question is how to remedy the violation." *Gagliano*, slip op. at 11. Concluding that Reliance made a mistake in not initially asserting the Pre-Existing Conditions Limitation as the basis to terminate Gagliano's disability benefits, the district court held that this "negligent failure" on the part of Reliance was a bar "to a second chance to litigate an issue." *Id.* at 15. Citing *Wenner v. Sun Life Assurance Co. of Canada*, 482 F.3d 878 (6th Cir. 2007), the district court opined that once Reliance denied Gagliano's claim for the reason given in the Initial Termination Letter, it could not thereafter support termination of "benefits for an entirely different and theretofore unmentioned reason" in the Second Termination Letter. *Wenner*, 482 F.3d at 882. To do so, the district court reasoned, nullifies "the opportunity

for ‘full and fair review’” as afforded by ERISA. “When an insurer changes the basis for its denial during the appeal process—whether during administrative review or judicial review—that opportunity is lost.”<sup>5</sup> Gagliano, slip op. at 10. Insomuch as the record reflected the basis for denial of benefits in the Initial Termination Letter was no longer valid,<sup>6</sup> and Reliance could not assert the Pre-Existing Conditions Limitation, no other basis existed in the record to deny Gagliano’s claim. The district court thus concluded an award to Gagliano of the long-term disability benefits was the appropriate remedy. “To allow an insurance company to benefit from its own negligence in the processing of an ERISA benefit claim would send the wrong message to insurers, unduly extend the review process, and pose potential unreasonable burdens on the judiciary, which would be faced with multiple rounds of litigation.” *Gagliano*, slip op. at 15.

Reliance contends the district court’s remedy was in error for several reasons. First, Reliance argues the

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<sup>5</sup> The district court also relied on an unpublished opinion from this circuit, *Thompson v. Life Insurance Co. of North America*, 30 Fed. Appx. 160 (4th Cir. Mar. 4, 2002) (unpublished), for this viewpoint. For the reasons set forth herein, *Thompson* appears incorrectly decided, but is of no precedential value in any event.

<sup>6</sup> The basis for terminating benefits in the Initial Termination Letter was that Gagliano was able to perform the functions of her employment and was not suffering from a covered disability. However, the IME conducted pursuant to the July 11 Order proved this rationale was not valid. The evaluating physician found that “Mrs. Gagliano’s current emotional and psychological condition would prevent her from returning to her job in the finance office of an automobile dealership.” Reliance did not contest this finding in the district court or on appeal.

district court ignored Fourth Circuit precedent which establishes "that state law claims for waiver and estoppel are pre-empted by ERISA," but that the court nonetheless applied the concept of waiver to estop Reliance from asserting the Pre-Existing Conditions Limitation. Second, Reliance contends the summary award of benefits to Gagliano is contrary to controlling Fourth Circuit precedent when a procedural ERISA violation is involved. Instead, Reliance contends a substantive remedy is inappropriate for a procedural ERISA violation and the correct remedy is a remand to the plan administrator for a "full and fair review." We agree with Reliance.

### 1. ERISA Preemption

In *White v. Provident Life & Accident Insurance Co.*, 114 F.3d 26 (4th Cir. 1997), the insurer issued an insurance policy based upon a legitimate "mistake." Upon discovery of the error, the insurer notified the insured of the mistake, tendered repayment of all premiums, and cancelled the policy. The insured asserted the insurer's "mistaken acceptance of premiums constituted a waiver of its right to deny" the validity of the policy. *Id.* at 29. We rejected that argument outright because an ERISA claimant:

cannot premise this waiver theory on state law. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. In *Holland v. Burlington Industries*, 772 F.2d 1140 (4th Cir. 1985), we specifically held that state law waiver and estoppel claims were preempted by ERISA, noting that such claims pose a risk of creating "conflicting employer obligations and

variable standards of recovery." This is precisely the result that ERISA's broad preemption clause was enacted to avoid.

Nor can White rely on the federal common law under ERISA, which does not incorporate the principles of waiver and estoppel.

*White*, 114 F.3d at 29. (citations omitted). See also *Crull v. GEM Ins. Co.*, 58 F.3d 1386, 1390 (9th Cir. 1995); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 58-59 (4th Cir. 1992); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1275-76 (6th Cir. 1991). Although the district court did not use the terms "waiver" or "estoppel," that is clearly the actual effect of the court's holding.

The "mistake" in *White* of negligently issuing the insurance policy could not create an equitable bar of waiver and estop the insurer from applying the ERISA plan as written and administering the Plan in compliance with ERISA which required cancellation of the insurance policy in question. Similarly, the "mistake" by Reliance in failing to initially assert the Pre-Existing Conditions Limitation cannot estop Reliance from asserting that exclusion under some notion of waiver because Reliance is required to administer the Plan as written, including the Pre-Existing Conditions Limitation. The district court's holding has the actual effect of deeming Reliance to have waived the Pre-Existing Conditions Limitation and estopping it from administering the Plan according to its terms. But as we made clear in *White*, "ERISA . . . does not provide for such unwritten modifications of ERISA plans. See 29 U.S.C. § 1102(a)(1) (requiring that '[e]very employee benefit

plan shall be established and maintained pursuant to a written instrument’); 29 U.S.C. § 1102(b)(3) (requiring that an ERISA plan describe the formal procedures by which the plan may be amended.)” *White*, 114 F.3d at 29. *See also Canada Life Assurance Co. v. Estate of Lebowitz*, 185 F.3d 231, 235 (4th Cir. 1999) (“This Court will enforce the plain language of an insurance policy unless it is in violation of ERISA.”); *Coleman*, 969 F.2d at 56 (“While a court should be hesitant to depart from the written terms of a contract under any circumstances, it is particularly inappropriate in a case involving ERISA, which places great emphasis upon adherence to the written provisions in an employee benefit plan.”); *Lockhart v. United Mine Workers of America 1974 Pension Trust*, 5 F.3d 74, 78 (4th Cir. 1993) (“The award of benefits under any ERISA plan is governed in the first instance by the language of the plan itself.”).

Under the terms of the Plan, a claimant with a pre-existing condition (as defined in the Plan) is not entitled to receive benefits. ERISA requires the Plan be administered as written and to do otherwise violates not only the terms of the Plan but causes the Plan to be in violation of ERISA. *See* 29 U.S.C. § 1102(a)(1) (2008). As the foregoing cases readily illustrate, the district court was without authority to direct the plan administrator to administer the Plan contrary to its terms by injecting the prohibited concepts of waiver and estoppel. Thus, the district court erred in making the effective holding that Reliance was estopped from asserting the Pre-Existing Conditions Limitation as a basis to deny Gagliano benefits under the Plan.

## 2. Remand

Insomuch as Reliance can assert the Pre-Existing Conditions Limitation, the district court's conclusion that Gagliano was entitled to summary judgment because there was no remaining basis for denial of the disability benefits is incorrect. Similarly, the district court's holding that the procedural ERISA violation, by virtue of the defective Second Termination Letter, entitled Gagliano to the substantive relief of an award of benefits is also in error.

Our decision in *Sedlack v. Braswell Services Group, Inc.*, 134 F.3d 219 (4th Cir. 1998), guides the result in this case. We determined in *Sedlack* that, as in the case at bar, a defective notice to a plan participant could not create a substantive remedy for a claim that was otherwise not cognizable under the terms of the ERISA plan.

Section 1133 requires that every plan "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1). Although the district court found that Braswell's notices were defective, it held that Sedlack could not recover for unreasonable claims practices because a breach of section 1133 does not provide a claimant with any new substantive rights. "Where, as here," the district court concluded, "Sedlack's claim is not covered, Braswell's breach of section 1133 would not entitle him to benefits or to an award of

damages.” This reasoning is sound and supported by persuasive judicial authority. See *Ashenbaugh v. Crucible Inc., 1975 Salaried Retirement Plan*, 854 F.2d 1516, 1532 (3d Cir. 1988) (noting “general principle” that “an employer’s or plan’s failure to comply with ERISA’s procedural requirements does not entitle a claimant to a substantive remedy”), *cert. denied*, 490 U.S. 1105; *Ellenburg v. Brockway, Inc.*, 763 F.2d 1091, 1096 (9th Cir. 1985) (“A substantive remedy would be appropriate only if the procedural defects caused a substantive violation or themselves worked a substantive harm.”).

*Sedlack*, 134 F.3d at 225.

Even though Reliance failed to provide Gagliano with the proper appeals notice required by ERISA in the Second Termination Letter, that procedural violation cannot afford Gagliano a substantive remedy if she has no entitlement to benefits under the terms of the Plan.<sup>7</sup> In cases where there is a procedural ERISA violation, we have recognized the appropriate remedy is to remand the matter to the plan

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<sup>7</sup> Whether the Pre-Existing Conditions Limitation does, in fact, apply is not an issue before the Court in this appeal. Even though Reliance argues on brief that the record proves the Pre-Existing Conditions Limitation applies, and thus we should enter judgment for Reliance, this argument is, at best, premature. Due to the failure of Reliance to comply with ERISA notice requirements, Gagliano was denied her right to make an administrative record on the Pre-Existing Conditions Limitation issue as well as other rights set forth in 29 C.F.R. § 2560-503-1(h). Reliance has no basis to receive a judgment in its favor at this stage of the proceedings.

administrator so that a "full and fair review" can be accomplished. "Normally, where the plan administrator has failed to comply with ERISA's procedural guidelines and the plaintiff/participant has preserved his objection to the plan administrator's noncompliance, the proper course of action for the court is remand to the plan administrator for a 'full and fair review.'" *Weaver*, 990 F.2d at 159. *See also Caldwell v. Life Ins. Co. of N. America*, 287 F.3d 1276, 1288-89 (10th Cir. 2002).

The only exception to that rule would be where the record establishes that the plan administrator's denial of the claim was an abuse of discretion as a matter of law. That was, in fact, the situation in *Weaver*, where the insurer "produced no evidence that it even remotely considered any specific reasons in denying the claim." *Weaver*, 990 F.2d at 159. No similar circumstance exists in the case at bar, as the record reflects, at minimum, a colorable claim that the Pre-Existing Conditions Limitation applies.

The district court's reliance on the Sixth Circuit's decision in *Wenner* was misplaced, both because it is contrary to the law of this circuit and because that decision's rationale is flawed. In *Wenner*, a claimant's ERISA benefits were ordered reinstated, a substantive remedy, even though the only ERISA violation was a 29 U.S.C. § 1133 procedural violation and the merits of the claim had not been decided. The dissent in *Wenner* correctly analyzed the frailty of the majority position and that of the district court in this case.

There is no legal basis to order the payment of benefits as a penalty for violation of the procedural requirements of ERISA. First, there

is no statutory basis in ERISA for the payment of benefits not otherwise required by the plan as a penalty for violating procedural requirements. We held, for instance, in *McCartha v. National City Corp.*, 419 F.3d 437, 447 (6th Cir. 2005), that a plan administrator's procedural violation did not require a substantive remedy because the administrator affirmed the initial benefits denial on appeal. Thus, even though the administrator violated 29 U.S.C. § 1133, the plaintiff was not entitled to a substantive remedy under ERISA because the administrator properly determined that the plaintiff was not entitled to disability benefits. *See also Marks v. Newcourt Credit Group, Inc.*, 342 F.3d 444, 461 (6th Cir. 2003); *Syed v. Hercules, Inc.*, 214 F.3d 155, 162 (3d Cir. 2000) (Alito, J.).

Reinstatement is not necessary in order to make the plaintiff whole for a procedural violation. The flaw in holding otherwise is that a plaintiff is *more* than made whole—and indeed receives a windfall—if after proper procedures it is determined that the plaintiff was not entitled to the benefits that the administrator terminated with flawed procedures.

*Wenner*, 482 F.3d at 884 (Rogers, J., dissenting).

By failing to follow the precedent in this Circuit established by *Sedlack* and *Weaver*, the district court erred in granting Gagliano a substantive remedy in the form of an award of disability benefits for a procedural violation of ERISA. The proper remedy was to remand to the plan administrator for the “full and

fair review" to which Gagliano is entitled regarding the denial of benefits on the basis of the Pre-Existing Conditions Limitation in the Second Termination Letter. Accordingly, the district court's award of summary judgment to Gagliano is reversed.<sup>8</sup>

### III.

For the foregoing reasons, the judgment of the district court is affirmed in part, reversed in part, and the case remanded for entry of an order to remand the case to the plan administrator for a full and fair review regarding the basis for denial of benefits in the Second Termination Letter.

*AFFIRMED IN PART,  
REVERSED IN PART,  
AND REMANDED*

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<sup>8</sup> As to Reliance's final issue on appeal the district court did not err in granting a motion to reconsider its earlier award of summary judgment to Reliance. The district court has considerable discretion in deciding whether to modify or amend a judgment. While it is true that it is a remedy to "be used sparingly," this Court has determined that a motion to alter or amend a judgment under Rule 59(e) is appropriate on three different grounds: "(1) to accommodate an intervening change in controlling law; (2) to account for new evidence not available at trial; or (3) to correct a clear error of law or prevent manifest injustice." *Pacific Ins. Co. v. Am. Nat'l Fire Ins. Co.*, 148 F.3d 396, 403 (4th Cir. 1998).

The district court did not err in holding that there was an error of law with respect to its earlier award of summary judgment to Reliance because the earlier judgment did not take into account the procedural violation of ERISA by Reliance. Accordingly, the district court's reconsideration of its prior judgment was appropriate.

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**APPENDIX B**

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**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF VIRGINIA  
Alexandria Division**

**No. 1: 03cv160**

**[Filed August 22, 2007]**

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JOANNE GAGLIANO,	)
Plaintiff,	)
	)
v.	)
	)
RELIANCE STANDARD LIFE	)
INSURANCE COMPANY,	)
Defendant.	)

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**MEMORANDUM OPINION**

Before the Court are cross motions for summary judgment concerning the Motion for Reconsideration filed by the plaintiff, Joanne Gagliano, in which she asks the Court to reconsider its decision to grant the Motion for Summary Judgment filed by defendant Reliance Standard Life Insurance Company and to vacate the judgment entered in favor of the defendant. For the reasons stated below, the plaintiff's Second Motion for Summary Judgment will be granted, the defendant's Motion for Summary Judgment will be denied, the previous judgment in favor of the

defendant will be vacated, and a judgment will be entered in the plaintiff's favor.

### **Procedural History and Factual Background**

Plaintiff, Joanne Gagliano ("Gagliano"), formerly known as Joanne Darvish, is a Virginia citizen who previously was an employee of DarCars Chrysler-Plymouth Jeep of Marlow Heights, which is owned by former defendant Mariam, Inc., a Maryland corporation that operates a group of car dealerships in the Washington, D.C. area. Mariam offers employees an employee welfare benefits plan ("the Plan") that is insured by defendant Reliance Standard Life Insurance Company ("Reliance"), an Illinois corporation. All claims against defendants Mariam and the Plan have been resolved, leaving Reliance as the only defendant in this civil action.

Although employed with DarCars since 1996, Gagliano did not begin the process of enrolling in the Plan until March 2001, shortly after she was treated at the Loudoun Hospital Center. On September 28, 2001, Gagliano was diagnosed with stress syndrome, anxiety disorder, depression and migraine by her treating physician and was advised to discontinue working at DarCars until her condition improved. On October 25, 2001, Gagliano filed a claim for short-term disability benefits with Reliance based on her mental health problems. Reliance approved that claim on or about December 28, 2001, and shortly after approving the claim for short-term disability benefits, Reliance began processing a rollover claim for long-term benefits.

On February 6, 2002, while considering Gagliano's eligibility for long-term benefits, Reliance sent a letter informing her that the plan's pre-existing condition exclusion might apply to her claim, and requesting information about any medical treatment she received in the three months immediately preceding her enrollment in the Plan. Under Section 2.0, the Plan would not pay benefits for a pre-existing condition, defined as "any Sickness or Injury for which the Insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three months immediately prior to the Insured's effective date of insurance." Gagliano's effective date of insurance was March 13, 2001.

Although it is unclear from the record whether Gagliano herself filled out the form titled "Pre-Existing Condition Questionnaire" or whether a Reliance employee helped her, it is clear that the questionnaire was timely filed, and it included information about Gagliano's treatment at the Loudoun Hospital Center. The administrative record reveals that Reliance subsequently obtained Gagliano's hospital records and that these records were considered by Dr. Gladys Fenichel during Reliance's review of Gagliano's eligibility for benefits under the Plan. Reliance approved the claim for long-term benefits on March 21, 2002, and started paying Gagliano long-term disability benefits effective January 16, 2002. Under the policy, the long-term disability benefits were limited to 24

months because the disability was based on a mental condition.<sup>1</sup>

On September 17, 2002, Reliance terminated Gagliano's long-term disability benefits ("initial termination"), after concluding that Gagliano did not continue to meet the eligibility requirements for a disability under the long-term disability group policy. This denial was based solely on Reliance's decision that Gagliano's mental health problems did not render her disabled. No mention was made in this initial termination of the pre-existing condition exclusion. Reliance indicated in its termination letter that its decision was based in part on the evaluation of Dr. Gladys Fenichel, its file reviewer.

Gagliano appealed that initial termination decision by a letter dated November 13, 2002. On January 21, 2003, Reliance advised Gagliano that although it was "required to make a decision within 60 days of the date of [her] appeal," it was "allowed an additional 60 days if circumstances do not permit us to make a decision within the initial 60 day time frame." In that letter Reliance also informed Gagliano that it would arrange for an Independent Medical Examination ("IME") to "continue to evaluate [her] claim in timely [sic] manner." Instead of submitting to the IME, Gagliano filed this civil action against Mariam, Reliance, and the Plan on February 5, 2003.

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<sup>1</sup> Gagliano received long-term disability benefits for eight months before the benefits were terminated, leaving the remaining sixteen months of benefits at issue in this lawsuit.

Reliance filed a Motion for Summary Judgment. On June 20, 2003, the motion was denied. Subsequently, Gagliano filed a Motion for Summary Judgment. During the hearing dealing with that motion, the Court determined that because the administrative review process had been cut short when the plaintiff filed her civil action rather than submitting to the IME, the administrative record was not complete. Accordingly, the Court stayed Gagliano's pending motion for summary judgment and ordered Reliance to arrange for an IME to "complete the administrative review process and render a final decision on plaintiff's administrative appeal."

Gagliano submitted to the IME, which resulted in a medical conclusion that she was indeed suffering from disabling mental problems, thus confirming that she remained entitled to continued disability benefits. However, on September 9, 2003, despite the results of the IME, Reliance denied Gagliano's claim by a letter that it described as its "final decision regarding [her] eligibility for benefits." In that final decision Reliance cited for the first time its position that Gagliano was not entitled to any disability benefits because her claim was "barred by the Policy's Pre-existing Conditions Limitation provision." Reliance admitted that it had made a mistake in approving Gagliano for benefits in the first place because of this exclusion. Although Reliance closed the letter by suggesting that it "would be happy to consider any additional information [Gagliano] wishe[d] RSL to review if the court thinks further review by RSL would be warranted in the present case," Reliance did not advise Gagliano in the letter that she was entitled to an administrative appeal of the new basis for denying her claim for benefits.

Gagliano's motion for summary judgment was renoticed for argument and each party filed a supplemental brief before the hearing. In Gagliano's brief, she maintained that Reliance could not deny her benefits on an entirely new basis without renewing her appeal rights. At the hearing, Reliance asserted that Gagliano had not been fully candid in informing Reliance about treatment at the Loudoun Hospital Center because she described it as involving "back and leg pain," and that if she had been fully candid, no benefits would ever have been paid to her.<sup>2</sup> In light of Reliance's argument and the documents before it, the Court denied Gagliano's Motion for Summary Judgment and sua sponte reconsidered and granted Reliance's previously denied motion for summary judgment.

The plaintiff filed the instant motion for rehearing and reconsideration, and a motion for relief from the judgment.<sup>3</sup> The court's trial calendar delayed resolution of those motions until now.

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<sup>2</sup> The "Pre-Existing Condition Questionnaire," filled out by hand, contains an entry underneath a question regarding hospital treatment giving the name and phone number of Loudoun Hospital Center and the notation "Reference: back and leg pain." Gagliano appears to have given information over the phone to a Reliance representative, who then faxed the form to Gagliano for her signature. The hospital record actually shows that Gagliano was being prescribed opioids and taking Tylenol for back and leg pain, the overdose of which led to her being hospitalized.

<sup>3</sup> Count I of the Complaint, a claim for benefits under ERISA § 502(a)(1)(B) against Reliance, is all that remains in this civil action.

In January 2007, the motions were noticed for hearing, and argument was heard on February 9, 2007. Counsel for Reliance did not appear. On February 9, 2007, the Court issued an order granting the motions for reconsideration and rehearing, denying the motions for relief from judgment, reopening discovery on the pre-existing condition exclusion, and directing the parties to re-file motions for summary judgment. The parties have now done so.

### Analysis

#### I. Standard of Review

The parties do not dispute that this case is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* Under ERISA, if the terms of an employee benefit plan provide discretionary authority to the fiduciary to determine a claimant's entitlement to benefits or to construe the terms of the plan, the fiduciary's decision must be afforded deference and should be overturned only if the decision is an abuse of discretion. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989); Doe v. Group Hospitalization & Medical Serv.'s, 3 F. 3d 80, 85 (4th Cir. 1993). The Plan provides such discretionary authority to Reliance. However, if a plan vests discretion in a plan administrator who is operating under a conflict of interest, the conflict must be taken into account when a court reviews the administrator's decision. Firestone, 489 U.S. at 115. A conflict exists if the administrator is not only the plan fiduciary, but also the insurer which necessarily benefits by denial of the claim. See Stup v. Unum Life Ins. Co., 390 F.2d 301, 307 (4th Cir. 2004). In such circumstances, deference is decreased "to the degree

necessary to neutralize any untoward influence resulting from the conflict.” Doe, 3 F.3d at 87. Because Reliance is operating under a financial conflict of interest in that it has a financial incentive to deny the plaintiff’s claim, deference is reduced and the standard applied is a reasonableness standard, as outlined in Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan, 201 F.3d 335, 342-43 (4th Cir. 2000).

## II. Discussion

Gagliano argues that as a matter of law Reliance has violated the notice provision of ERISA Section 502, 29 U.S.C. § 1133, which requires that a participant whose benefits have been denied be given notice in writing “setting forth the specific reasons for such denial,” and also requires the participant to have “a full and fair review by the appropriate named fiduciary of the decision denying the claim.” 29 U.S.C. § 1133. This Court reviews de novo the legal question of whether Reliance complied with the notice requirements of ERISA when it denied Gagliano’s claim in its appeal decision.

ERISA § 502, codified at 29 U.S.C. § 1133, provides:

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been

denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133. The governing regulation for ERISA claims procedures, 29 C.F.R. § 2560.503-1, sets forth detailed and particularized processes for making claims, determining benefits, and providing for review of adverse benefit determinations. Regulation § 2560.503-1(h) specifically asserts that

the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures (i) provide claimants at least 60 days following receipt of notification of an adverse benefit determination within which to appeal the determination; (ii) provide claimants with the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (iii) provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits...; (iv) provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

29 C.F.R. § 2560.503-1 (emphasis added).

It is uncontested that Reliance failed to comply with the notice requirements of ERISA, because it never afforded Gagliano the opportunity to appeal its decision to terminate her benefits on the new ground of the pre-existing condition exclusion. Reliance informed Gagliano of the new reason for terminating her benefits in its letter of September 9, 2003, at the same time that it recognized that she did, indeed, suffer from an eligible disability based on the IME. However, it neither offered her an opportunity to appeal the new, determinative reason for terminating her benefits nor even advised her of the right to have her evidence considered on the factual question of the pre-existing condition limitation. Instead, the parties returned to court for the argument of motions.

Reliance now argues that Gagliano is precluded from contesting the denial of benefits on that new ground because her evidence is not part of the administrative record. This argument is disingenuous, as it is not Gagliano's fault that she was not afforded the chance to submit evidence on this question to the administrative reviewer.

Case law in the Fourth Circuit and elsewhere holds that insurers cannot change the basis for a denial of benefits without offering an opportunity for appeal because ERISA requires that claimants have the opportunity for "full and fair review" of all determinative reasons for the denial of benefits claims. When an insurer changes the basis for its denial during the appeal process—whether during administrative review or judicial review—that opportunity is lost. See Thompson v. Life Insurance Company of North America, 30 Fed. Appx. 160, 163-64, 2002 U.S. App. LEXIS 3390 (4th Cir. 2002)

(unpublished) (remanding to district court where insurance company changed reason for its denial of benefits during judicial appeal because allowing insurer "to raise a new basis for denial would deprive [the claimant] of the procedural fairness guaranteed to claimants under ERISA"); see also Wenner v. Sun Life Assurance Company of Canada, 482 F.3d 878, 880-82 (6th Cir. 2007) (reinstating terminated benefits where insurance company changed basis for termination after administrative appeal was filed because "full and fair review" language is inconsistent with insurance company "denying [the claimant's] claim for one reason, and then turning around and terminating his benefits for an entirely different and theretofore unmentioned reason, without affording him the opportunity to respond to the second, determinative reason for the termination"); Glista v. Unum Life Insurance Company of America, 378 F.3d 113, 130 (1st Cir. 2004) (remanding to the district court with instructions that the insurer be held to the reason articulated during its internal claims review process since the insurer "violated ERISA and its regulations by relying on a reason in court that had not been articulated to the claimant during its internal review").

Having concluded that Reliance violated ERISA, the remaining question is how to remedy the violation. Reliance argues that the proper remedy for this procedural violation of ERISA is a remand to the insurance company to allow Gagliano to submit evidence on the question of the pre-existing condition. See Weaver v. Phoenix Home Life Mut. Ins. Co., 990 F.2d 154, 159 (4th Cir. 1993) ("Normally, where the plan administrator has failed to comply with ERISA's procedural guidelines and the plaintiff/participant has

preserved his objection to the plan administrator's noncompliance, the proper course of action for the court is remand to the plan administrator for a "full and fair review"). Only a remand, Reliance argues, would allow the parties to develop fully the administrative record for further judicial review.

Gagliano argues that a reinstatement of the improperly terminated benefits is the appropriate remedy. See Wenner, 482 F.3d at 882 (expressly recognizing that a "procedural violation does not require a substantive remedy" under ERISA, but determining that the appropriate remedy was to reinstate all benefits beginning from the invalid termination because where the initial grant of benefits was terminated in violation of § 1133 of ERISA, the benefits had never been properly revoked). Moreover, Gagliano argues that a remand is not appropriate because Reliance abused its discretion by continuously denying Gagliano her appeal rights in violation of ERISA. See Weaver, 990 F.2d at 159 ("a remand for further action is unnecessary here because the evidence clearly shows that [the insurer] abused its discretion.").<sup>4</sup>

There is no question that if on initial remand Reliance had limited its review to the question of Gagliano's eligibility for benefits on grounds of her mental illness, it would have been an abuse of

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<sup>4</sup> Reliance actually argues that a remand is appropriate but unnecessary, since the factual evidence in the record demonstrates the applicability of the pre-existing condition exclusion. This argument demonstrates Reliance's further effort to evade the dictates of ERISA, which require that Reliance consider evidence offered by Gagliano on this question.

discretion for Reliance to have affirmed that termination after the IME sustained Gagliano's claim of being disabled. The IME clearly demonstrated to all parties that Gagliano was, in fact, entitled to benefits on the ground of her mental illness, and a decision to the contrary would have been unreasonable and not supported by the evidence. As the Fourth Circuit held in Thompson, in reviewing an appeal of an initial decision, the insurer is limited to whether the rationale set forth in the initial denial notice is reasonable. Under this reasoning, a second remand is unnecessary because the result is clear: Gagliano is entitled to benefits on grounds of her disability.

Reliance argues that because it made a mistake in approving Gagliano for benefits in the first place, it should have the benefit of a second remand to allow the parties to develop a complete evidentiary record on the pre-existing condition exclusion. Reliance initially suggested at oral argument that its mistaken award of benefits was the result of Gagliano's failure to be forthcoming about her previous hospital treatment. However, the record clearly demonstrates that, in fact, Gagliano did not purposefully withhold information from Reliance. In fact, Gagliano provided Reliance with all of the information it needed to contact the Loudoun Hospital Center before it granted Gagliano long-term benefits in the first place. Of particular significance is the clear evidence that Dr. Fenichel reviewed those hospital records almost a month before Reliance made its initial termination decision. The records put Dr. Fenichel on clear notice that Gagliano was treated for a Tylenol and possible opioid overdose and was hospitalized for three nights. During the hospital stay, Gagliano received a psychiatric consult and reported to the consulting doctor that she had

been prescribed Xanax. In her pleadings before the Court, Gagliano maintains that the psychiatric consult was a five-minute, pre-release standard procedure, that she took Xanax for one and a half days, and that she did not follow the hospital's suggestion that she seek further psychiatric treatment. Nothing prevented Reliance from citing to the pre-existing condition exclusion when it initially terminated Gagliano's benefits. It was only because of Reliance's negligence and not due to any misconduct on Gagliano's part that Reliance failed to cite the pre-existing condition exclusion as the basis for initially terminating Gagliano's benefits. Reliance now asks this Court for a remand to correct that mistake.

In evaluating Reliance's request for another opportunity to review this claim, the Court has used the same analysis that applies when a party requests that a court reconsider a decision or alter or amend a judgment based on newly discovered evidence. Such a request will not be granted unless the party can demonstrate, among other factors, that the evidence on which it relies is truly newly discovered. See, e.g., United States ex rel. Becker v. Westinghouse Savannah River Co., 305 F.3d 284, 290 (4th Cir. 2002). On this record, Reliance cannot argue that the new basis for denial of benefits was based on newly discovered evidence, when in fact, that evidence had been in Reliance's possession throughout the claims process. Usually, a party who negligently misses available facts is not entitled to a second chance to litigate an issue. This principle preserves limited judicial resources and promotes efficient and timely restoration of disputes. Moreover, given the equitable nature of the protections found in ERISA, denying an insurance company's request for a second chance based

on its negligent failure to consider all the evidence in the record is clearly appropriate.

To allow an insurance company to benefit from its own negligence in the processing of an ERISA benefit claim would send the wrong message to insurers, unduly extend the review process, and pose potential unreasonable burdens on the judiciary, which would be faced with multiple rounds of litigation. Had Gagliano concealed evidence that came to light only during judicial review, the equitable balance in this case would be different. However, the record demonstrates that she appropriately complied with Reliance's requests for information throughout the administrative review process. It was Reliance's failure to evaluate that evidence in its initial processing of Gagliano's claims that led to this litigation. As such, it should not benefit from that negligence. On these facts, Gagliano remains entitled to receive the remaining sixteen months of benefits.

### **Conclusion**

Accordingly, for the reasons stated above, Gagliano's Second Motion for Summary Judgment will be GRANTED, and Reliance's Motion for Summary Judgment will be DENIED.

A separate order consistent with this opinion will be entered.

Entered this 22<sup>nd</sup> day of August, 2007.

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/s/ Leonie M. Brinkema  
Leonie M. Brinkema  
United States District Judge

Alexandria, Virginia

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**APPENDIX C**

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**TITLE 29. LABOR  
CHAPTER 18. EMPLOYEE RETIREMENT  
INCOME SECURITY PROGRAM  
PROTECTION OF EMPLOYEE  
BENEFIT RIGHTS  
GENERAL PROVISIONS**

**29 U.S.C. § 1002. Definitions**

For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

\* \* \*

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

\* \* \*

**TITLE 29. LABOR  
CHAPTER 18. EMPLOYEE RETIREMENT  
INCOME SECURITY PROGRAM  
PROTECTION OF EMPLOYEE  
BENEFIT RIGHTS  
REGULATORY PROVISIONS  
ADMINISTRATION AND ENFORCEMENT**

**29 U.S.C. § 1132. Civil enforcement**

(a) Persons empowered to bring a civil action. A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

\* \* \*

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

**29 U.S.C. § 1133. Claims procedure**

In accordance with regulations of the Secretary, every employee benefit plan shall--

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

---

**APPENDIX D**

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**UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF VIRGINIA  
Alexandria Division**

**No. 03-160-A**

**[Filed February 5, 2003]**

---

JOANNE GAGLIANO	)
45 Huntley Court	)
Sterling, Virginia 20165	)
	)
Plaintiff,	)
	)
v.	)
	)
MARIAM, INC.	)
t/a DARCARS AUTOMOTIVE	)
GROUP	)
A Maryland Corporation	)
12214 Cherry Hill Rd.	)
Silver Spring, Maryland 20904	)
	)
SERVE: Stephen Hosea	)
6411 Ivy Lane, Suite 200	)
Greenbelt, Maryland 20770	)
	)
and	)
	)
UNNAMED LONG TERM DISABILITY	)
INSURANCE PLAN FOR EMPLOYEES	)

OF DARCARs	)
12214 Cherry Hill Rd.	)
Silver Spring, Maryland 20904	)
	)
SERVE: Hon. Elaine L. Chao	)
Secretary of Labor	)
200 Constitution Avenue, N.W.	)
Washington, D.C. 20210	)
	)
and	)
	)
RELIANCE STANDARD LIFE	)
INSURANCE COMPANY	)
2001 Market Street, Suite 1500	)
Philadelphia, Pennsylvania 19103-7090	)
	)
SERVE: Commonwealth Legal	)
Services Corp.	)
4701 Cox Road, Suite 301	)
Glen Allen, Virginia 23060	)
	)
Defendants	)
_____	)

**COMPLAINT**

**(Action For ERISA Benefits, Civil  
Penalties, Breach of Fiduciary Duty,  
Injunction and Damages)**

COMES NOW Plaintiff, Joanne Gagliano, by  
counsel, and makes her Complaint against the  
defendants as follows:

### Parties

1. Plaintiff Joanne Gagliano, formerly known as Joanne Darvish (hereinafter "Gagliano" or "plaintiff"), is an adult citizen of the United States and a resident of the Commonwealth of Virginia.

2. Defendant Mariam, Inc. (hereinafter "Mariam") is a Maryland corporation with a principal place of business in Silver Spring, Maryland. Mariam trades under the name of DarCars Automotive Group and operates a group of automobile dealerships in the Washington, D.C. metropolitan area.

3. Defendant Unnamed Long Term Disability Insurance Plan for Employees of DarCars (hereinafter "Plan") is a welfare benefit plan providing long term disability benefits for employees of Mariam. The Plan is an employee benefit plan as defined by the Employment Retirement Income Security Act of 1974 (hereinafter "ERISA"), Title 29 U.S.C. Sections 1001 *et seq.* The Plan's sponsor has either failed to name the Plan, or such name is unknown to plaintiff.

4. Defendant Reliance Standard Life Insurance Company (hereinafter "Reliance") is an Illinois corporation with a principal place of business in Chicago, Illinois.

5. At all times relevant hereto, defendant Mariam was present and doing business in the Commonwealth of Virginia by virtue of its operation of an automobile dealership at 10620 Lee Highway, Fairfax, Virginia 22030 and by virtue of its acting as plan administrator of an ERISA plan providing benefits paid to residents of the Commonwealth of Virginia, including plaintiff.

6. At all times material hereto, defendant Plan was present in the Commonwealth of Virginia by virtue of its provision of insurance benefits to participants and beneficiaries who reside and/or are employed in the Commonwealth of Virginia, including plaintiff.

7. At all times material hereto, defendant Reliance was present and doing business in the Commonwealth of Virginia by virtue of its providing insurance benefits to residents of the Commonwealth of Virginia, including plaintiff.

### **Jurisdiction and Venue**

8. This Court has jurisdiction of this matter under Title 29 U.S.C. Section 1132(e) and (f) (ERISA jurisdiction), as well as Title 28 U.S.C. Section 1331 (federal question jurisdiction).

9. This Court has jurisdiction of this matter under Title 28 U.S.C. Section 1332 (diversity jurisdiction) as the matter in controversy exceeds the sum or value of Seventy-Five Thousand Dollars (\$75,000.00), exclusive of interest and costs, and is between citizens of different states.

10. Venue is proper in this district and division, as they are the district and division where plaintiff resides, where the breaches took place, and where defendants can be found.

### **Operative Facts**

11. At all times material hereto, plaintiff Gagliano was a full-time employee of DarCars Chrysler-

Plymouth Jeep of Marlow Heights (hereinafter "DarCars CPJ").

12. Defendant Mariam owns and operates, and at all times material hereto has owned and operated, DarCars CPJ.

13. In calendar years 2001 and 2002, Gagliano was eligible for long term disability insurance offered by Mariam as a plan participant of the Plan.

14. Such disability insurance was offered through an ERISA welfare benefit plan insured by defendant Reliance.

15. On or about April 1, 1996, defendant Mariam became plan sponsor and plan administrator of defendant Plan.

16. As plan administrator of the Plan, Mariam is a fiduciary with respect to the Plan.

17. As the claims review fiduciary with respect to the Plan, defendant Reliance is a fiduciary with respect to the Plan.

18. Upon information and belief, the Plan fiduciaries have not created a Summary Plan Description ("SPD") with respect to the Plan.

19. On September 28, 2001, plaintiff Gagliano was diagnosed with stress syndrome, anxiety disorder, depression and migraine by her treating physician and was advised by him to cease employment with DarCars CPJ until her condition improved.

20. On October 25, 2001, plaintiff Gagliano made a claim for short term disability benefits with defendant Reliance.

21. On or about December 18, 2001, defendant Reliance approved plaintiff's application for short term disability benefits.

22. On or about January 7, 2002, plaintiff Gagliano made a claim for long term disability benefits under the Plan by providing information and documents requested by defendant Reliance.

23. On March 21, 2002, defendant Reliance approved long term disability benefits for plaintiff; such long term disability benefits commenced as of January 16, 2002.

24. On September 17, 2002, defendant Reliance made an adverse benefit determination with respect to plaintiff Gagliano by terminating her long term disability benefits under the Plan previously approved by defendant Reliance.

25. The reason given by defendant Reliance in its notice of adverse benefits determination was that plaintiff Gagliano allegedly did not continue to meet the eligibility requirements under the long term disability group policy.

26. On November 13, 2002, plaintiff Gagliano transmitted a written request for review of the decision of September 17, 2002 regarding termination of long term disability benefits. Said request for review was received by defendant Reliance on November 15, 2002.

27. On January 21, 2003, defendant Reliance advised plaintiff Gagliano that it was unable to make a decision with respect to her long term disability benefits and would be taking an additional unspecified amount of time to reach a decision regarding her request for review dated November 13, 2002.

28. At all times material hereto, plaintiff Gagliano has paid all required premiums with respect to her long term disability benefits.

29. At all times material hereto, plaintiff Gagliano has met all eligibility requirements for long term disability coverage.

30. Defendant Reliance has failed and refused to provide long term disability benefits plaintiff to Gagliano, and such failure is continuing.

**COUNT I**  
**(Claim for Benefits Under**  
**ERISA Section 502(a)(1)(B):**  
**Mariam, Plan and Reliance)**

31. All previous paragraphs are realleged as if fully set forth hereat.

32. As of March 21, 2002, plaintiff Gagliano met all requirements for receipt of long term disability benefits under the Plan as a plan participant.

33. Since March 21, 2002, there has been no material change in her mental and emotional health.

34. As of September 17, 2007, and thereafter, plaintiff Gagliano has met and currently meets all

requirements for the receipt of long term disability benefits from Reliance.

35. The adverse benefit determination of September 17, 2002 is contrary to the terms of the group contract for long term disability benefits relating to the Plan.

36. Defendant Mariam, as plan administrator, has not provided to defendant Reliance discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits for plan participants and beneficiaries. The adverse benefit determination of defendant Reliance is therefore void.

37. Alternatively, if defendant Reliance has provided proper discretionary authority to defendant Reliance to interpret the Plan and the insurance policy and to determine eligibility for benefit participants and beneficiaries, such discretionary authority has been exercised by defendant Reliance arbitrarily, capriciously and contrary to the information available to it regarding plaintiff's disability. In such regard, defendant Reliance has:

a. failed to consider that plaintiff had previously met all requirements for long term disability benefits and failed to expressly identify and consider any new facts apparent from the record that are material and substantial enough to cause the prior determination to grant benefits to be reversed;

b. made no reference to, or given consideration to, the provisions of any Summary Plan Description relating to the Plan;

c. failed to articulate a rational basis for the adverse benefit determination that is supported by the record;

d. failed to consider the opinions of plaintiff's treating health care providers that plaintiff is unable to work;

e. failed to consider that the review of plaintiff's record performed prior to the adverse benefit determination by Reliance fails to demonstrate an ability to return to work;

f. relied on a document review of plaintiff's record that is incomplete and has mischaracterized the findings of plaintiff's treating health care providers; and,

g. failed to examine or test plaintiff with respect to her disability prior to making its adverse benefit determination.

38. Defendants have failed to establish and maintain reasonable claims procedures, in violation of ERISA and its regulations. In that regard, the defendants:

a. have failed to establish and maintain claims procedures that comply with the requirements of paragraphs (d), (g), (h), and (i) of 29 CFR 2560.503-1;

b. have failed to set forth the description of all claims procedures and the applicable time frames in a Summary Plan Description meeting the requirements of 29 CFR 2520.102-3; and,

c. have failed to establish or maintain claims procedures containing administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents.

39. The notification of the adverse benefit determination sent to plaintiff did not set forth a specific reason or reasons for the adverse determination, but was general and conclusory.

40. The notification of the adverse benefit determination sent to plaintiff did not make reference to the specific plan provisions on which the determination was based.

41. The notification of the adverse benefit determination sent to plaintiff did not contain a description of any additional material or information necessary for the plaintiff to perfect her claim and an explanation of why such material or information was necessary, including, but not limited to a specification of what material or information would cure the perceived deficiency in plaintiff's medical records that led defendants to the conclusion that plaintiff was not totally disabled.

42. The notification of the adverse benefit determination sent to plaintiff did not provide the correct time limits applicable to the Plan's review procedures.

43. The notification of adverse benefit determination sent to plaintiff failed to include a statement of the plaintiff's right to bring a civil action

under Section 502(a) of ERISA following an adverse benefit determination on review.

44. The defendants failed to notify the plaintiff of the Plan's benefit determination on review within forty-five (45) days after receipt of plaintiff's request for review by the Plan.

45. Defendants failed to provide written notice of an extension of the 45-day period aforesaid within such 45-day period, failed to indicate the special circumstances requiring an extension of time, and failed to state the date by which the Plan expected to render the determination on review.

46. The actions and omissions aforesaid by the defendants have provided plaintiff with no reasonable opportunity for a full and fair review of her claim and adverse benefit determination, and such acts and omissions are in violation of ERISA and its regulations.

47. By virtue of the failure of the defendants to establish and follow reasonable claims procedures and the failure of the defendants to provide a full and fair review of claims and adverse benefits determinations, plaintiff Gagliano is deemed to have exhausted her administrative remedies and is entitled to pursue all available remedies under Section 502(a) of ERISA without judicial deference to the adverse benefit determination.

48. As a direct and proximate result of the actions and omissions of the defendants aforesaid, plaintiff Gagliano has been damaged.

WHEREFORE, plaintiff Gagliano prays for the entry of an injunction, both preliminary and permanent, against defendants Mariam, the Plan and Reliance, directing said defendants to provide all accrued long term disability benefits denied the plaintiff as a result of the adverse benefit determination of September 17, 2002; that said defendants be enjoined, both preliminarily and permanently, from making any adverse benefit determinations as to plaintiff Gagliano until such time as they have established a full and fair review of claims and adverse benefit determinations, as well as establishing and following reasonable claims procedures; that, in the alternative, judgment be awarded plaintiff Gagliano against defendants Mariam, the Plan and Reliance, jointly and severally, for payment of benefits due her under the terms of the Plan in the amount of One Hundred Thousand Dollars (\$100,000.00), plus pre-judgment interest; that plaintiff Gagliano be awarded attorneys' fees as provided under ERISA, payment of her costs of this action, and all such other and further relief as the Court may deem just and proper.

## COUNT II

### (Action Under ERISA Section 502(c): Mariam)

49. All previous paragraphs are realleged as if fully set forth hereat.

50. At all times material hereto, defendant Mariam, as plan administrator, was required by operation of federal law to provide plaintiff Gagliano with a copy of the SPD with respect to the Plan upon request.

51. At all times material hereto, defendant Mariam, as plan administrator, was required by operation of federal law to provide plaintiff Gagliano with a copy of any insurance contracts associated with the Plan upon request.

52. At all times material hereto, defendant Mariam, as plan administrator, was required by operation of federal law to provide plaintiff Gagliano with copies of all summary annual reports relating to the Plan upon request.

53. At all times material hereto, defendant Mariam, as plan administrator, was required by operation of federal law to provide plaintiff Gagliano with copies of any other documents under which the long term disability benefits plan is operated and maintained upon request.

54. On October 3, 2002, plaintiff Gagliano, by and through her counsel, made a written request upon defendant Mariam for copies of the SPD, any insurance contracts associated with the Plan, copies of all summary annual reports for the last three years relating to the Plan, and any other document under which the long term disability benefits Plan is operated or maintained.

55. On November 12, 2002, plaintiff Gagliano, by her counsel, made a telephonic request to defendant Mariam at its office of human resources, for documents responding to the October 3, 2002 request.

56. On December 9, 2002, plaintiff Gagliano, by her counsel, made a further written request upon

defendant Mariam for the documents set forth in the written request of October 3, 2002.

57. Defendant Mariam has failed to provide a copy of any of the requested documents or make any other response to the requests of plaintiff Gagliano.

58. The failure of defendant Mariam as aforesaid is a violation of ERISA Section 502(c) and subjects it to civil penalties under ERISA, all of which are due and payable to plaintiff Gagliano.

WHEREFORE, plaintiff Gagliano demands judgment against defendant Mariam for civil penalties at the rate of One Hundred Ten Dollars (\$110.00) per day per document for its failure to provide copies of Plan documents as requested from November 2, 2002 to the date of judgment herein and that plaintiff Gagliano be awarded her attorneys' fees under ERISA, plus payment of her costs, along with such other and further relief as the Court may deem just and proper.

### **COUNT III**

#### **(Breach of Fiduciary Duty for Failure to Establish and Maintain Reasonable Claims Procedures; Equitable Relief Under ERISA Section 502(a)(3): Mariam and Reliance)**

59. All previous paragraphs are realleged as if fully set forth hercat.

60. At all times material hereto, defendants Mariam and Reliance, as ERISA fiduciaries, had a duty of loyalty pursuant to which all decisions regarding an ERISA plan must be made solely in the interests of plan participants, as well as other

fiduciary duties including but not limited to those duties listed hereafter.

61. At all times material hereto, defendants Mariam and Reliance, as ERISA fiduciaries, had a duty to act for the exclusive purpose of providing benefits to plan participants.

62. At all times material hereto, defendants Mariam and Reliance, had a duty to act in accordance with any documents or instruments governing the Plan.

63. Defendants Mariam and Reliance breached their fiduciary duties to plaintiff Gagliano by their failure to provide plaintiff Gagliano with a full, fair, unbiased and competent review of her medical records and other pertinent information prior to making the initial adverse benefit determination, by their failure to provide plaintiff Gagliano with notification of the adverse benefit determination that meets the minimum standards required under ERISA, by their failure to provide plaintiff Gagliano with a full and fair review of the adverse benefit determination made on September 17, 2002, as is required under ERISA, and by their failure to establish and maintain reasonable claims procedures.

64. As a direct and proximate result of the aforesaid breaches of fiduciary duties, plaintiff Gagliano has been damaged.

WHEREFORE, plaintiff Gagliano prays for the entry of an injunction, both preliminary and permanent, against defendants Mariam and Reliance, directing said defendants to provide all accrued long

term disability benefits denied the plaintiff as a result of the adverse benefit determination of September 17, 2002, plus pre-judgment interest; that said defendants be enjoined, both preliminarily and permanently, from making any adverse benefit determinations as to plaintiff Gagliano until such time as they have established a full and fair review of claims and adverse benefit determinations, as well as establishing and following reasonable claims procedures; that plaintiff Gagliano be awarded attorneys' fees as provided under ERISA, payment of her costs of this action, and all such other and further relief as the Court may deem just and proper.

#### **COUNT IV**

**(Breach of Fiduciary Duty for Failure to  
Provide All Information Needed to Enforce  
Rights of Plan Participants; Equitable Relief  
Under ERISA Section 502(a)(3):  
Mariam and Reliance)**

65. All previous paragraphs are realleged as if fully set forth hereat.

66. At all times material hereto, defendants Mariam and Reliance, as ERISA fiduciaries, had a duty to furnish to each participant all information that he or she needs to enforce his or her rights under the Plan.

67. At all times material hereto, defendants Mariam and Reliance, as ERISA fiduciaries, had a duty to furnish each participant with an SPD relating to the Plan.

68. Defendants Mariam and Reliance have breached their fiduciary duties by failure to provide plaintiff Gagliano with a copy of the SPD relating to the Plan.

69. Defendants Mariam and Reliance have breached their fiduciary duties to plaintiff Gagliano by failing to furnish her with all other information that she needs to enforce her rights under the Plan.

70. As a direct and proximate result of the aforesaid breaches of fiduciary duties, plaintiff Gagliano has been damaged.

WHEREFORE, plaintiff Gagliano prays for the entry of an injunction, both preliminary and permanent, against defendants Mariam and Reliance, directing said defendants to provide all accrued long term disability benefits denied the plaintiff as a result of the adverse benefits determination of September 17, 2002, plus pre-judgment interest; that said defendants be enjoined, both preliminarily and permanently, from making any adverse benefit determinations as to plaintiff Gagliano until such time as they have provided to plaintiff Gagliano all information that she needs to enforce her rights under the Plan, including a copy of the Summary Plan Description; that plaintiff Gagliano be awarded attorneys' fees as provided under ERISA, payment of her costs of this action, and all such other and further relief as the Court may deem just and proper.

**COUNT V**

**(Breach of Fiduciary Duty for Failure to  
Establish and Maintain Reasonable Claims  
Procedures; Relief Under ERISA Section  
502(a)(2): Mariam and Reliance)**

71. All previous paragraphs are realleged as if fully set forth hereat.

72. At all times material hereto, defendants Mariam and Reliance owed the fiduciary duties aforesaid in connection with the Plan not only to plaintiff Gagliano, but also to the Plan itself and all of its participants and beneficiaries.

73. Defendants Mariam and Reliance, in breach of their fiduciary duties aforesaid, have failed to establish, maintain and implement claims procedures that notify claimants of benefit determinations in accordance with the requirements of ERISA.

74. Defendants Mariam and Reliance, in breach of their fiduciary duties, have failed to establish, maintain and implement procedures by which claimants have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the Plan.

75. Defendants Mariam and Reliance, in breach of their fiduciary duties as aforesaid, have failed to establish, maintain and implement procedures under which there will be a full and fair review of claims and adverse benefit determinations.

76. Such breaches of fiduciary duty have permitted defendants Mariam and Reliance to profit at the

expense of the participants and beneficiaries of the Plan, and such actions constitute deliberate, willful, wanton and malicious breaches of fiduciary duty.

77. Such actions and omissions on the part of defendants Mariam and Reliance are the direct and proximate cause of damage to the Plan as well as to its participants and beneficiaries.

WHEREFORE, plaintiff Gagliano requests that a judgment issue against defendant Reliance requiring full restitution to the Plan of all insurance premiums and other consideration it has received in connection with the Plan; that defendant Reliance be ordered to account for all such payments and consideration, as well as any profits it has received as a result; that all profits be restored for the benefit of the Plan; that a constructive trust be imposed upon defendant Reliance for purposes of assuring repayment of all premiums, consideration and profits with respect to the Plan; that an injunction, both preliminary and permanent, issue against defendants Mariam and Reliance prohibiting further violations of ERISA with respect to the Plan; that compensatory damages be awarded by the Court against defendants Mariam and Reliance and in favor of the Plan in an amount necessary to compensate the Plan, its participants and beneficiaries for all losses caused by Mariam and Reliance; that pre-judgment interest be awarded against defendants Mariam and Reliance; that judgment be imposed against defendants Mariam and Reliance for punitive damages in the amount of Five Hundred Thousand Dollars (\$500,000.00); that defendant Reliance be removed as claims fiduciary of the Plan; that defendant Mariam be removed as a fiduciary under the Plan and ordered to forthwith employ an independent and competent

fiduciary to serve as plan administrator; that plaintiff Gagliano be awarded her attorneys' fees under ERISA; that she be awarded her costs, and that she be awarded such other and further relief as the Court may deem just and proper.

### **COUNT VI**

#### **(Breach of Fiduciary Duty for Failure to Provide All Information Needed to Enforce Rights of Plan Participants; Relief Under ERISA Section 502(a)(2): Mariam and Reliance)**

78. All previous paragraphs are realleged as if fully set forth hereat.

79. At all times material hereto, defendants Mariam and Reliance owed the fiduciary duties aforesaid in connection with the Plan not only to plaintiff Gagliano, but to the Plan itself and all of its participants and beneficiaries.

80. Defendants Mariam and Reliance, in breach of their fiduciary duties as aforesaid, have failed to provide plan participants and beneficiaries with copies of the Summary Plan Description.

81. Defendants Mariam and Reliance, in breach of the fiduciary duties aforesaid have failed to furnish each participant and beneficiary all other information that he or she needs to enforce his or her rights under the Plan.

82. Such breaches of fiduciary duty have permitted defendants Mariam and Reliance to profit at the expense of the participants and beneficiaries of the

Plan, and such actions constitute deliberate, willful, wanton and malicious breaches of fiduciary duty.

83. Such actions and omissions on the part of defendants Mariam and Reliance are the direct and proximate cause of damage to the Plan as well as to its participants and beneficiaries.

WHEREFORE, plaintiff Gagliano requests that a judgment issue against defendant Reliance requiring full restitution to the Plan of all insurance premiums and other consideration it has received in connection with the Plan; that defendant Reliance be ordered to account for all such payments and consideration, as well as any profits it has received as a result; that all profits be restored for the benefit of the Plan; that a constructive trust be imposed upon defendant Reliance for purposes of assuring repayment of all premiums, consideration and profits with respect to the Plan; that an injunction, both preliminary and permanent, issue against defendants Mariam and Reliance prohibiting further violations of ERISA with respect to the Plan; that compensatory damages be awarded by the Court against defendants Mariam and Reliance and in favor of the Plan in an amount necessary to compensate the Plan, its participants and beneficiaries for all losses caused by Mariam and Reliance; that pre-judgment interest be awarded against defendants Mariam and Reliance; that judgment be imposed against defendants Mariam and Reliance for punitive damages in the amount of Five Hundred Thousand Dollars (\$500,000.00); that defendant Reliance be removed as claims fiduciary of the Plan; that defendant Mariam be removed as a fiduciary under the Plan and ordered to forthwith employ an independent and competent fiduciary to serve as plan administrator; that plaintiff

Gagliano be awarded her attorneys' fees under ERISA; that she be awarded her costs, and that she be awarded such other and further relief as the Court may deem just and proper.

JOANNE GAGLIANO  
By Counsel

BORING & PILGER, P.C.

/s/

Karl W. Pilger, Esq. (Bar #18788)  
307 Maple Avenue West, Suite D  
Vienna, Virginia 22180-4307  
(703)281-2161  
Attorney for Plaintiff Joanne Gagliano

Dated February 5, 2003

**VERIFICATION**

I, Joanne Gagliano, hereby certify that I have read the foregoing Complaint, and state that it is true and correct to the best of my knowledge and belief.

/s/ Joanne Gagliano

Joanne Gagliano

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(3)

Supreme Court, U.S.  
FILED

APR 30 2009

OFFICE OF THE CLERK

No. 08-1068

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**In The  
Supreme Court of the United States**

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JOANNE GAGLIANO,

*Petitioner,*

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

*Respondent.*

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*On Petition for Writ of Certiorari to the United  
States Court of Appeals for the Fourth Circuit*

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**BRIEF IN OPPOSITION**

---

JOSHUA BACHRACH

*Counsel of Record*

WILSON, ELSER, MOSKOWITZ,

EDELMAN & DICKER LLP

THE CURTIS CENTER

SUITE 1130 EAST

INDEPENDENCE SQUARE WEST

PHILADELPHIA, PA 19106

(215) 627-6900

*Counsel for Respondent*

April 30, 2009

**CORPORATE DISCLOSURE STATEMENT**

Respondent Reliance Standard Life Insurance Company hereby discloses that it is a subsidiary of Reliance Standard Life Insurance Company of Texas, which in turn is a subsidiary of Delphi Financial Group, Inc., which is a publicly held corporation.

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## ARGUMENT

### I. Introduction

This lawsuit involves a claim for disability benefits under an ERISA plan.<sup>1</sup> Petitioner seeks review of the Fourth Circuit's decision to remand the claim back to respondent due to a procedural irregularity during the administrative review process. Petitioner argues that certiorari should be granted based on a split in the circuits on the proper remedy when a plan discontinues benefits through a defective procedure. According to petitioner, in other circuits, the remedy is to reinstate benefits. There is no split in the circuits on this subject.

Contrary to the position of petitioner, the cases she cites in her brief do not involve the same or similar facts to the ones in this case. In each of the cases relied on by petitioner from outside of the Fourth Circuit, there was no dispute that the claimant was eligible for benefits prior to the defective termination. Here, petitioner is attempting to obtain benefits under an ERISA plan without ever proving that she met the eligibility requirements. To the extent that the authority cited by petitioner can be stretched so thin as to cover the facts in this case, and if the Court then finds a split in the circuits, this is still not the appropriate case for this Court to resolve the issue. Therefore, the petition should be denied.

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<sup>1</sup> The Employee Retirement Income Security Act of 1974.

**II. The Facts in this Case are Unique, Therefore, the Issue is different from the Cases Relied on by Petitioner**

Petitioner suggests that there is a split in the circuits regarding the appropriate remedy when a claimant has not received a full and fair review of an adverse benefit determination as required under ERISA. This broad statement fails to recognize the unique facts that were presented to the circuit court in this case. Specifically, petitioner is relying on a procedural irregularity to continue to receive benefits that were improperly awarded and that she was never entitled to receive under the plain language in the Plan. None of the cases cited by petitioner involve these facts.

Petitioner stopped working in September of 2001 and submitted a claim for long term disability benefits under the Plan based on anxiety disorder and related symptoms. Pet. App. 3a. Because petitioner was not enrolled in the Plan for 12 consecutive months before claiming disability, her claim was subject to the Plan's pre-existing conditions limitation. Pet. App. 4a. During the initial claim process, petitioner completed a questionnaire in which she denied prior treatment for a similar condition. *Id.* Respondent promptly approved the claim and began paying disability benefits.

After paying benefits for several months, respondent notified petitioner that long term disability benefits were being discontinued based on updated medical information which did not support the claim that she remained disabled. *Id.* Petitioner administratively appealed the discontinuation of

benefits. During the appeal, respondent notified petitioner that it was scheduling an independent medical examination in accordance with the terms of the Plan. Pet. App. 28a. Instead of appearing for the independent medical examination, petitioner prematurely filed this lawsuit. *Id.*

Respondent filed a motion for summary judgment in the district court based, in part, on petitioner's failure to exhaust her administrative remedies as required under ERISA. Pet. App. 29a. The district court agreed that petitioner should have appeared for the independent medical examination and exhausted her administrative remedies before filing her lawsuit. *Id.* Accordingly, the district court remanded the claim to respondent to conduct an independent medical examination and "complete the administrative review process and render a final decision on plaintiff's administrative appeal." *Id.*

During the administrative appeal, respondent learned that the disability claim never should have been approved. Contrary to petitioner's response on the pre-existing condition questionnaire, petitioner was hospitalized for "stress syndrome/anxiety disorder" during the treatment free period before her individual coverage commenced. Pet. App. 6a. In fact, this hospitalization occurred just days before petitioner enrolled in the Plan. Pet. App. 27a. Because petitioner received treatment immediately before her effective date of coverage for a condition "which caused, contributed to or resulted in her eventual Total Disability . . ." respondent upheld the decision to discontinue benefits. Pet. App. 6a.

The district court's remand order, which preceded the second decision letter, required respondent to "render a final decision on [the] administrative appeal." Pet. App. 6a. Based on this language, the appeal denial letter did not include language regarding petitioner's appeal rights under ERISA. *Id.* Nevertheless, because the second decision letter included a new basis for the claim denial, respondent told counsel for petitioner that it "would be happy to consider any additional information" if permitted by the Court." Pet. App. 7a.

The Fourth Circuit ultimately concluded that respondent's offer to "consider any additional information" did not substantially comply with the requirements of ERISA. Pet App. 15a. However, the court of appeals reversed the judgment of the district court which ordered reinstatement as the remedy for the procedural violation. Pet. App. 16a-17a. Instead, the Fourth Circuit concluded that the proper remedy is to "remand the case to the plan administrator for a full and fair review regarding the basis for the denial of the benefits in the Second Termination Letter." Pet. App. 24a.

Petitioner suggests to this Court that the Fourth Circuit's decision in this case conflicts with decisions from the Third, Sixth, Seventh, and Ninth Circuits. Contrary to this argument, none of the decisions cited by petitioner involve facts that are even remotely similar.

The Third Circuit easily found a procedural violation in *Grossmuller v. Int'l Union et al.*, 715 F.2d 852 (CA3 1983). There, the Plan failed to establish procedures, failed to identify the evidence it relied on

in terminating benefits, failed to notify the claimant of his right to examine evidence or present rebuttal evidence and violated its own past practice by allowing a third party to appear before the appeal committee. *Grossmuller*, 715 F.2d at 858. Because there was no dispute as to the claimant's eligibility prior to the improper discontinuation of benefits, the Third Circuit concluded that the proper remedy was to reinstate benefits from the time of the improper denial. *Id.*

The decision of the Sixth Circuit also involved the discontinuation of benefits that were previously approved. See *Wenner v. Sun Life Assur. Co.*, 482 F.3d 878 (CA6 2007). Like the Third Circuit in *Grossmuller*, the Sixth Circuit concluded that the denial of benefits did not comply with the requirements of ERISA. *Wenner*, 482 F.3d at 883. Unlike the case presently before this Court, there was no dispute in *Wenner* as to the correctness of the benefit payments prior to the discontinuation of benefits. Accordingly, the court ordered reinstatement of benefits. *Id.* The same facts were also present in *Schneider v. Sentry Group Long-Term Disability Plan*, 422 F.3d 621 (CA7 2005), which is relied on by petitioner.

The Ninth Circuit decision cited by petitioner differs even more from this case and the ones described above. See *Pannebecker v. Liberty Life Assur. Co.*, 542 F.3d 1213 (CA9 2008). *Pannebecker* did not involve a defective denial notice. The Court instead concluded that defendant failed to properly apply the Plan provisions and also failed to make a reasonable inquiry into the claim. *Pannebecker*, 542 F.3d at 1220-21. Based on this flawed review, the court ordered reinstatement of benefits.

Petitioner's case presents facts that are different from all of these cases. Based on the pre-existing conditions limitation in the Plan, respondent never should have approved the disability claim. Giving petitioner every benefit of the doubt, the Fourth Circuit remanded the claim to respondent so that petitioner will have the opportunity to submit evidence that the pre-existing conditions limitation does not apply to her claim. Pet. App. 24a. Petitioner is not satisfied with this remedy, however. Obviously, petitioner recognizes that there is no evidence that she can submit which will eliminate the lack of coverage based on the pre-existing conditions language in the Plan.

There is a significant distinction between a discontinuation of benefits based on a finding that the claimant is no longer disabled and a plan's realization that the claimant never met the eligibility requirements. In all cases, a claimant's eligibility must be based on the language in the plan documents.<sup>2</sup> There is no language in the ERISA statute that supports an award of benefits to an ineligible person because there was a procedural irregularity.<sup>3</sup> This is

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<sup>2</sup> See *Gutta v. Standard Select Trust*, 530 F.3d 614, 621 (CA7 Cir. 2008); *Wal-Mart Stores v. Gamboa*, 479 F.3d 538, 543 (CA8 Cir. 2007); *High v. E-Systems, Inc.*, 459 F.3d 573, 580 (CA5 Cir. 2006).

<sup>3</sup> Petitioner argues that if a court orders reinstatement of benefits and it is ultimately decided that the payments are contrary to the plan language, the plan can recoup these payments if the plan documents include the proper language. Pet. Br. 18. Although a plan may include language permitting the recovery of erroneously paid benefits, the bigger issue tends to be the participant's dissipation of those funds before a judgment is entered. On the other hand, if the claim is remanded and the participant

the only case cited to this Court that involves these facts. Therefore, there is no split in authority and review by this Court is not needed.

### **III. The Third, Sixth, Seventh and Ninth Circuits Have Also Remanded Claims When Appropriate**

Contrary to the impression left by petitioner, the above-noted circuits do not apply an inflexible rule when confronted with a procedural violation during the claim process. While it is true that in the single case from each circuit cited by petitioner the courts ordered reinstatement of benefits, in other decisions from those same circuits the claims were remanded. These differing decisions demonstrate that courts award an appropriate remedy based on the facts of the individual case.

Petitioner refers this Court to the decision in *Grossmuller*, in which the Third Circuit ordered reinstatement of benefits after finding numerous procedural violations. *Grossmuller*, 715 F.2d at 858. However, the Third Circuit has not always concluded that reinstatement of benefits is the proper remedy when a plan fails to provide a full and fair review. See *Syed v. Hercules, Inc.*, 214 F.3d 155 (CA3 2000). In *Syed*, disability benefits were paid for two years before the claimant was notified that benefits were terminated. The claimant argued that the denial letter did not comply with ERISA's notice

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ultimately proves eligibility for benefits, there is no harm by the delay in payment. As petitioner recognizes, a court can award pre-judgment interest. Pet. Br. 19.

requirements. Although the court disagreed with the plaintiff's argument, then Circuit Judge Alito stated that "the remedy for a violation of Section 503 is to remand to the Plan Administrator so the claimant gets the benefit of a full and fair review." *Syed*, 214 F.3d at 162.

The Sixth Circuit is no different. In *Wenner*, the court concluded that reinstatement of benefits was the appropriate remedy for the procedural violation. *Wenner*, 482 F.3d at 883. A different result was reached by the same court in *McCartha v. National City Corp.*, 419 F.3d 437 (CA6 2005). In *McCartha*, the disability plan paid benefits for several months before sending a termination letter. The Sixth Circuit determined that the Plan was not in substantial compliance with Section 503 of ERISA because it failed to provide the participant with one of the reasons for terminating benefits. *McCartha*, 419 F.3d at 447.

Unlike *Wenner*, the Sixth Circuit did not order reinstatement of benefits in *McCartha*. It did not even remand the claim for further review by the Plan. The Court held that a remand to the Plan would be a "useless formality" because the claimant could not produce additional evidence proving that the one basis for denying benefits that was properly communicated to the claimant was arbitrary and capricious. *McCartha*, 419 F.3d at 447. Contrary to the position advanced by petitioner, in affirming the judgment in favor of the Plan, the Sixth Circuit in *McCartha* stated that a "procedural violation does not require a substantive remedy." *Id.*

Petitioner also refers to the Seventh Circuit's decision in *Schneider*, in which the court ordered

reinstatement of benefits based on the failure of the denial notice to comply with ERISA. In other cases, the Seventh Circuit concluded that the appropriate remedy was to remand the claim to the plan for further review. *Wolfe v. J.C. Penny Co.*, 710 F.2d 388 (CA7 1983); *Quinn v. Blue Cross and Blue Shield*, 161 F.3d 472 (CA7 1998). In *Quinn*, the Seventh Circuit stated that “[a]warding retroactive benefits is not always the proper remedy . . . .” *Quinn*, 161 F.3d at 477.

Petitioner may argue that *Quinn* is distinguishable because it involved the Plan’s failure to make adequate findings. Such a distinction is irrelevant. The ERISA statute does not discriminate in this matter. It broadly states that a plan must provide a “full and fair review” of an adverse decision. 29 U.S.C. § 1133(a).

The Ninth Circuit has also ordered different remedies for a procedural violation. In *Pannebecker*, the Plan discontinued benefits after it concluded that the claimant was no longer disabled. The district court initially concluded that the defendant failed to properly apply the terms of the Plan and remanded the claim for further review. On remand, the Plan again concluded that the claimant was not entitled to additional benefits. *Pannebecker*, 542 F.3d at 1215. This time, the district court upheld the denial of benefits. *Id.* On appeal, the Ninth Circuit held that the district court should have ordered retroactive reinstatement of disability benefits from the time of

the defective denial until the post remand decision.<sup>4</sup> *Pannebecker*, 542 F.3d at 1220-21.

In other cases in which the defendant has misconstrued the terms of the plan, the Ninth Circuit has ordered a remand rather than reinstatement of benefits. See *Saffle v. Pacific Power Co.*, 85 F.3d 455, 461 (CA9 1996). ("We now make explicit, that remand for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator with discretion . . . has misconstrued the Plan and applied a wrong standard to a benefits determination."). See also *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026 (CA9 2006).

Even the Fourth Circuit, where this case originated, has not always remanded claims for further review after finding a procedural violation. See *Weaver v. Phoenix Home Life Mutual Ins. Co.*, 990 F.2d 154 (CA4 1993). The Fourth Circuit explained that "a remand for further action is unnecessary" where the evidence clearly establishes that the defendant abused its discretion. *Weaver*, 990 F.2d at 159. This argument cannot be made in petitioner's case, however.

Contrary to the basis for the petition presently before this Court, the cases cited above show that courts do not automatically remand claims for further review or automatically reinstate benefits depending

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<sup>4</sup> It is odd, to say the least, that the Ninth Circuit upheld the Plan's conclusion that the claimant was not disabled when the benefits were originally terminated but retroactively awarded a portion of the disputed benefits to the claimant based on a procedural violation.

on the circuit. Courts instead look to the specific facts in a particular case before deciding the appropriate remedy. Simply put, there is no split in the circuits. Rather, there are different decisions in each circuit based on the facts that are presented.

#### **IV. The Facts of This Case Make It Inappropriate for Review**

To the extent that a split in the circuits can be found, this not the appropriate case to resolve the issue. This case does not involve an innocent plan participant who was misled by the plan. It involves a claimant who provided inaccurate information regarding her medical history to the Plan on a pre-existing conditions questionnaire. Pet. App. 27a. Additionally, petitioner's treating therapist failed to mention a "serious hospitalization" during the treatment free period in which petitioner received mental health treatment for the same condition on which she bases her disability claim. JA 886. In a hearing before the district court on October 20, 2003, before the district court reconsidered the ruling entered on that date, the judge recognized that the therapist's reports failed to "mention several key facts which would have . . . clearly put the insurance company on clear and fair notice of the pre-existing condition . . . ." JA 905-906. No new evidence was presented on reconsideration that could alter that conclusion.

Petitioner also interfered with respondent's investigation of the claim, and the applicability of the pre-existing conditions limitation, when she prematurely filed this lawsuit in an effort to avoid appearing for an independent medical examination.

Pet. App. 28a-29a. Significantly, when the independent medical examination finally took place pursuant to an order of the district court, the doctor clearly linked petitioner's hospitalization immediately before she became insured under the Plan to her disability claim several months later. JA 1068-1071.

After concluding that respondent did not provide petitioner "with the proper appeals notice required by ERISA in the Second Termination Letter," the Fourth Circuit remanded the claim to the Plan for a full and fair review of the denial based on the pre-existing conditions limitation. Pet. App. 21a. According to this limitation in the Plan, benefits are not payable for a disability based on a pre-existing condition, which is defined as "any Sickness or Injury for which the Insured received medical treatment, consultation, care or services . . . during the three months immediately prior to the Insured's effective date of insurance." Pet. App. 4a. The goal of the Fourth Circuit was for there to be a decision based on the merits and the Plan language after petitioner received a "full and fair review." Petitioner does not want that to happen. She wants a court to award benefits based on a technicality and without regard to her actual eligibility. Based on petitioner's own actions during the claim process, this request is especially unwarranted.

**CONCLUSION**

For the reasons stated above, the petition for a writ of certiorari should be denied.

Respectfully submitted,

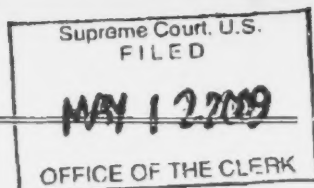
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128 (4) No. 08-1068



In The  
Supreme Court of the United States

JOANNE GAGLIANO,

*Petitioner,*

v.

RELIANCE STANDARD LIFE INS. CO.,

*Respondent.*

ON PETITION FOR WRIT OF CERTIORARI  
TO THE UNITED STATES COURT OF APPEALS  
FOR THE FOURTH CIRCUIT

REPLY BRIEF OF PETITIONER

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*Dated: May 12, 2009*

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## REPLY BRIEF FOR THE PETITIONER

On February 17, 2009, a petition for a writ of certiorari was filed in this case. On March 23, 2009, this Court called for a response. As explained herein, the opposition filed by respondent does not seriously challenge the validity of the reasons for granting the writ set forth in the petition. It is beyond dispute that the circuits are divided over the question presented; the question is extremely important, and immediate review is needed. As such, petitioner respectfully requests that the Court grant the petition or, in the alternative, call for the views of the Solicitor General.

### I. THERE IS A SQUARE CIRCUIT SPLIT OVER THE QUESTION PRESENTED

1. The question presented in this case presumes three things: (1) an ERISA welfare plan approved a claim for benefits, (2) the plan thereafter decided to terminate the payment of such benefits, and (3) a court has determined that the termination was in violation of the procedures required by 29 U.S.C. § 1133 and applicable regulations. This case presents a paradigmatic example. Petitioner's claim for long term disability benefits was approved by respondent. Pet. 5 (citing Pet. App. 49a). Thereafter, respondent decided to terminate the payment of such benefits. Pet. 6 (citing Pet. App. 59a). And, ultimately, the Fourth Circuit held that respondent's termination of benefits was in violation of the procedures required by 29 U.S.C. § 1133 and regulations promulgated thereunder. Pet. 8 (citing Pet. App. 15a).

As the Fourth Circuit expressly acknowledged, it created a split with its sister circuits who, under such circumstances, have held that ERISA permits the judicial reinstatement of disputed benefits until they are terminated by the plan in compliance with the statute's required procedures. Pet. 10 (quoting Pet. App. 22a). Unlike the Fourth Circuit, the Third, Sixth, Seventh, and Ninth Circuits have each held that ERISA permits, at a minimum, such reinstatement in order to preserve the status quo "until a decision regarding the potential revocation of \* \* \* benefits has been properly determined in compliance with the plan's provisions." Pet. 11 (quoting *Wenner v. Sun Life Assurance Co.*, 482 F.3d 878, 883 (CA6 2007); see also Pet. 10-13 (discussing *Wenner*, *Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3d 621 (CA7 2005); *Grossmuller v. Int'l. Union et al.*, 715 F.2d 853 (CA3 1983), and *Pannebecker v. Liberty Life Assurance Co.*, 542 F.3d 1213, 1221 (CA9 2008)).<sup>1</sup>

2. Before this Court, respondent takes the untenable position that "[t]here is no split in the circuits on this subject." BIO 1. In support of this position, respondent advances two arguments. First, respondent argues that "the facts in this case are unique" and, therefore, concludes that the Fourth Circuit decided a different question than the one decided by the Third, Sixth, Seventh, and Ninth

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<sup>1</sup> As explained in the petition, the Ninth Circuit appears to go even further and permit a claimant to recover benefits for the period between a plan's procedurally improper denial and a procedurally proper denial *even if* the court ultimately agrees with the plan fiduciary that the claimant was never substantively entitled to the disputed benefits under the terms of the plan. See Pet. 15 n 20 and accompanying text.

Circuits. BIO 2-7. Second, respondent contends that the Third, Sixth, Seventh, and Ninth Circuits do not always permit the reinstatement of benefits in cases in which the question presented is at issue. BIO 7-11. As explained below, each of these two arguments is frivolous.

a. Respondent first argues that the issue decided by the Fourth Circuit is somehow different from the issue decided by the Third, Sixth, Seventh, and Ninth Circuits. BIO 2-7. Specifically, respondent argues that “the facts in this case are unique” because “petitioner is relying on a procedural irregularity to continue to receive benefits that were improperly awarded and that she was never entitled to receive under the plain language in the Plan.” BIO 2. Put simply, respondent’s argument is frivolous because it conflates respondent’s *litigation position* (i.e., that petitioner “was never entitled to receive [benefits]”) with a *judicial determination*.

As explained in the petition, “the court of appeals made clear that the substantive question of whether petitioner qualified for benefits under the Plan was *not* before the court” *because of the very procedural violations committed by respondent*. Pet. 8. In the words of the Fourth Circuit:

Even though [respondent] argues [ ] that the record proves the Pre-Existing Conditions Limitation applies, and thus we should enter judgment for [it], this argument is, at best, premature. Due to the failure of [respondent] to comply with ERISA notice

requirements, [petitioner] was denied her right to make an administrative record on the Pre-Existing Conditions Limitation issue as well as other rights set forth in 29 C.F.R. 2560-503-1(h).

Pet. 8-9 (quoting Pet. App. 21a). Respondent's argument and, in fact, its entire opposition, is predicated on acceptance of its *unresolved* litigation position that petitioner was never entitled to receive benefits. See, e.g., BIO 11-12 (repeatedly citing documents from the joint appendix of the Fourth Circuit in support of disputed factual claims that were never addressed by the court of appeals).

b. Second, respondent argues that there is no circuit split because "The Third, Sixth, Seventh and Ninth Circuits Have Also Remanded Claims When Appropriate." BIO 7. Again, respondent's argument is frivolous. None of the cases it cites, in any way cast doubt over the square circuit split regarding the question presented.

*Third Circuit.* Respondent cites *Syed v. Hercules, Inc.*, 214 F.3d 155 (CA3 2000) for the proposition that "the Third Circuit has not always concluded that reinstatement of benefits is the proper remedy when a plan fails to provide a full and fair review." BIO 7. Even a cursory review of that decision, however, reveals that the case did not involve the question presented. The Third Circuit did not even reach the issue of what remedy is appropriate for a procedural violation of 29 U.S.C. § 1133 because the court held that no such violation had occurred. *Syed*, 214 F.3d at 163 (affirming the grant of summary

judgment dismissing Syed's claim under 29 U.S.C. § 1133 after finding that the ERISA plan administrator "fully complied with the statutory and regulatory requirements for notice under ERISA § 503, and [that] Syed ha[d] not raised any genuine issue of material fact to the contrary.").

*Sixth Circuit.* Respondent cites *McCartha v. National City Corp.*, 419 F.3d 437 (CA6 2005) for the proposition that, even in the Sixth Circuit, "a procedural violation does not require a substantive remedy." BIO 8 (quoting *McCartha*, 419 F.3d at 447). *McCartha*, however, is perfectly consistent with the Sixth Circuit's decision in *Wenner*. Although the *McCartha* court found a violation of 29 U.S.C. § 1133, it did not reinstate benefits (but rather affirmed the district court's judgment on the administrative record dismissing plaintiff's claim) because it *also* reached the merits of the dispute and determined that the claimant was not substantively entitled to benefits. 710 F.2d at 393. Put simply, *McCartha* only serves to reinforce the existence, depth, and importance of the circuit split.<sup>2</sup>

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<sup>2</sup> To be clear: *McCartha* confirms, as intimated in the petition, that there is a 3-way circuit split over the question presented. The Fourth Circuit does not permit reinstatement of benefits terminated in a procedurally improper fashion unless the termination of benefits "was an abuse of discretion as a matter of law" (i.e., the court determines that the claimant is *substantively* entitled to benefits). *Gagliano*, 547 F.3d at 240. The Sixth Circuit permits reinstatement of benefits terminated in a procedurally improper fashion unless the termination of benefits was substantively proper as a matter of law (i.e., the court determines that the claimant is *not* substantively entitled to benefits). *Wenner*, 482 F.3d at 883. And the Ninth Circuit permits reinstatement of benefits terminated in a procedurally improper fashion *even if* the

*Seventh Circuit.* Respondent cites *Wolfe v. J.C. Penney Co.*, 710 F.2d 388 (CA7 1983) and *Quinn v. Blue Cross and Blue Shield*, 161 F.3d 472 (CA7 1998) for the proposition that “[a]warding retroactive benefits is not always the proper remedy \* \* \*” BIO 9. As with the Third Circuit case cited by respondent, even a cursory review of these two Seventh Circuit decisions reveal that they did not involve the question presented. Put simply, neither case involved a *termination* of benefits that would have continued absent the procedural violation. *Wolfe* involved an *initial* denial of a claim for long term disability benefits and *not* a termination of a previously granted claim.<sup>3</sup> *Wolfe*, 710 F.2d at 388. And *Quinn* expressly notes that it is different from *Grossmuller* (the relevant Third Circuit case) and

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denial of benefits was substantively proper as a matter of law. *Pannebecker*, 542 F.3d at 1221. The Third and Seventh Circuits have rejected the position taken by the Fourth Circuit and, at a minimum, embraced the position taken by the Sixth Circuit. *Grossmuller*, 715 F.2d at 852 and *Schneider*, 422 F.3d at 621.

<sup>3</sup> “[ ] the distinction is important: A plaintiff denied any benefits at all has no expectation of receiving them unless her claim is meritorious, and thus returning her to the status quo prior to the § 1133 violation requires only curing the procedural violation so that she may fairly pursue the merits of her claim. On the other hand, a plaintiff whose benefits have been terminated has, prior to the termination, a full expectation of continued disability payments until they are terminated by lawful procedures. Thus, “prior to the termination of her benefits by improper procedures, the status quo was that [the plaintiff] was receiving long-term disability benefits” and “the appropriate remedy is an order vacating the termination of her benefits and directing [the defendant] to reinstate retroactively the benefits.” See *Schneider*, 422 F.3d at 629-30.” *Wenner*, 482 F.3d at 883, 884.

*Halpin v. W.W. Grainger Inc.*, 962 F.2d 685 (CA7 1992) (the original Seventh Circuit case relied on in *Schneider*) because “[u]nlike *Halpin* and *Grossmuller*, Quinn was not scheduled to continue receiving benefits under the Program.” *Quinn*, 161 F.3d at 478.

*Ninth Circuit.* Respondent cites *Saffle v. Sierra Pacific Power Co.*, 85 F.3d 455, 461 (CA9 1996) and *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026 (CA9 2006) for the proposition that “the Ninth Circuit has ordered a remand rather than reinstatement of benefits.” BIO 10. Again, these cases obviously do not involve the question presented. *Saffle* involved an *initial* denial of a claim for long term disability benefits and *not* a termination of a previously granted claim. *Saffle*, 85 F.3d at 461. And *Chuck* is a retirement plan case in which the violation of 29 U.S.C. 1133 was relevant only for purposes of determining the application of the statute of limitations. *Chuck*, 455 F.3d at 1026.

## II. RESPONDENT DOES NOT SERIOUSLY DISPUTE THAT THE QUESTION IS OF EXTRAORDINARY IMPORTANCE

Unsurprisingly, respondent fails to meaningfully dispute that the question presented is frequently recurring and exceptionally important. In fact, the extraordinary importance of the question is evidenced by respondent's conspicuous failure to contest the following empirical claims made in the petition:

- “Millions of Americans are covered by employer-sponsored disability insurance.” Pet. 13 (citations omitted).
- “[M]illions of Americans have welfare benefit claims denied each year.” Pet. 2 (citations omitted).
- “Because disability claims are often wrongfully denied or terminated, the question presented affects an extraordinary number of potential claimants.” Pet. 14 (citation omitted).

With regard to plan fiduciaries, respondent concedes that the question presented is of exceptional importance. As noted in the petition, “the question presented is [ ] of extraordinary importance to fiduciaries [because h]aving to continue paying improperly granted—or no longer owed—disability benefits during the pendency of the administrative process means that fiduciaries will be forced to rely on recoupment provisions \* \* \* in order to recover monies received by claimants to which there was no legitimate entitlement.” Pet. 15. Respondent appears to agree with this contention. BIO 6 n.3 (“Although a plan may include language permitting the recovery of erroneously paid benefits, the bigger issue tends to be the participant’s dissipation of those funds before a judgment is entered.”).

With regard to claimants, respondent half-heartedly disputes the importance of the question presented by asserting in passing that “if [a] claim is

remanded and the participant ultimately proves eligibility for benefits, there is no harm by the delay in payment [because] as petitioner recognizes, a court can award pre-judgment interest." BIO 6-7 n.3. As noted in the petition, however, "disability benefit claimants are often unable to work." Pet. 14 (citation omitted). And "[b]eing able to eventually recover back payments with interest is hardly comforting to those individuals who are completely reliant on continued benefits in order to pay for basic living expenses." Pet. 14-15. Tellingly, respondent does not even attempt to respond to this argument.

### III. RESPONDENT DOES NOT SERIOUSLY DISPUTE THAT IMMEDIATE REVIEW IS NEEDED

In the petition, two arguments are advanced in support of the proposition that immediate review of the question presented is needed. First, petitioner argued that "there is a strong need for national uniformity regarding the question presented given its importance and the underlying purpose of ERISA." Pet. 16. Second, petitioner argued that "further percolation is likely to proceed slowly while yielding little—if any—benefit." Pet. 17. Tellingly, respondent fails to address—let alone dispute—either of these contentions.

Instead, respondent contends that "this [sic] not the appropriate case to resolve the issue." BIO 11. Rather than advance some argument regarding the appropriateness of this case as a vehicle for resolution of the question presented, however, respondent merely cites several disputed facts from

the joint appendix filed in the court of appeals.<sup>4</sup> As explained above, these facts have absolutely no legal significance.

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<sup>4</sup> Inexplicably, respondent also cites Pet. App. 27a for the proposition that "claimant [ ] provided inaccurate information regarding her medical history to the Plan on a pre-existing conditions questionnaire." BIO 11 (citing Pet. App. 27a). Of course, the Fourth Circuit opinion cited by respondent says no such thing. To the contrary, it states that "[a]lthough it is unclear from the record whether Gagliano herself filled out the form titled 'Pre-Existing Condition Questionnaire' or whether a Reliance employee helped her, it is clear that the questionnaire was timely filed, and it included information about Gagliano's treatment at the Loudoun Hospital Center." Pet. App. 27a.

## CONCLUSION

For all the reasons discussed above and in the petition, immediate guidance is needed from this Court regarding the proper resolution of the question presented. As such, petitioner respectfully requests that the Court grant the petition or, in the alternative, call for the views of the Solicitor General.

Respectfully submitted,

/s/

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SUPREME COURT, U.S.

**Supreme Court of the United States**

JOANNE GAGLIANO,

*Petitioner,*

v.

RELIANCE STANDARD  
LIFE INSURANCE COMPANY,  
*Respondent.*

**ON PETITION FOR WRIT OF CERTIORARI TO THE  
UNITED STATES COURT OF APPEALS FOR  
THE FOURTH CIRCUIT**

**BRIEF OF PATIENT ADVOCATE FOUNDATION  
AS AMICUS CURIAE  
IN SUPPORT OF PETITIONER**

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## INTEREST OF *AMICUS CURIAE*

*Amicus curiae*, Patient Advocate Foundation (hereinafter “amicus”) respectfully submits this brief in support of petitioner, Joanne Gagliano, encouraging the grant of a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit, because that judgment is inconsistent with the language and intent of the ERISA statute, and with sound public policy.<sup>1</sup>

The Patient Advocate Foundation is a not for profit, Section 501(c)(3) charitable organization that assists individuals who are facing serious or life-threatening illnesses obtain access to health care. Amicus employs a staff of experienced patient navigators who respond to calls for help from individuals throughout the United States who are having difficulties obtaining access to health care under various public and private health benefit plans and programs. Patients are not charged for this service.

In 2007, Patient Advocate Foundation offered direct services to 44,812 individuals. These patients were from all fifty states and represented diversity

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<sup>1</sup> Pursuant to Rule 37, the parties have consented to the filing of this brief, and written consents are being filed with the Clerk of Court contemporaneously with this brief. Pursuant to this Court's Rule 27.6, *amicus* represents that this brief was not authored, in whole or in part, by counsel for any party and that no party other than *amicus* has made a monetary contribution to the preparation or submission of this brief.

in age, ethnicity, geographic location and socio-economic status. Seventy eight percent of these individuals were diagnosed with cancer. Seventy seven percent of these patients were insured. A significant number of these individuals were eligible for group health benefits under ERISA employee welfare benefit plans.<sup>2</sup> The statutory definition of an "employee welfare benefit plan" includes "any plan, fund or program" that provides employees with "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment." 29 U.S.C. § 1002(1) [emphasis added].

In this case, Petitioner Gagliano is challenging the termination of *disability* benefits by Respondent. It is important to note that group *health* benefits are governed by the same "employee welfare benefit plan" statutory provisions and regulations. The Fourth Circuit opinion therefore will have a significant impact on millions of individual welfare plan beneficiaries with health benefit claims.

Amicus regularly assists patients whose health benefits have been denied or terminated. These patients have a significant interest in the issue presented by this case: when benefits are terminated in violation of the procedures required by 29 U.S.C. § 1133 and implementing regulations, does 29 U.S.C. § 1132(a)(3) permit a court to reinstate

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<sup>2</sup> Patient Advocate Foundation, *2007 Patient Data Analysis Report* (Published February 2008).

those benefits (or enjoin their termination) until they are terminated in compliance with ERISA?

## **SUMMARY OF THE ARGUMENT**

The question presented by Petitioner in this case will have a significant impact on millions of individuals with health benefit claims under ERISA group health plans, because the statutory definition of an "employee welfare benefit plan" includes both disability benefits and health benefits. 29 U.S.C. § 1002(1). Amicus assists patients whose health benefits have been denied or terminated, and it is concerned that the Fourth Circuit's ruling could jeopardize potentially life-saving treatment for patients in situations where coverage is terminated during the course of treatment. Where health benefits are terminated by a plan administrator without complying with the patient's procedural safeguards established by 29 U.S.C. § 1133 and regulations promulgated thereunder, the patient should be allowed to have health benefits continue until the plan administrator complies with ERISA's procedural protections.

## **THE FOURTH CIRCUIT DECISION BELOW CONFLICTS WITH THE THIRD, SIXTH, SEVENTH, AND NINTH CIRCUITS.**

### **REASONS FOR GRANTING THE WRIT**

#### **I. THE QUESTION PRESENTED IS EXTREMELY IMPORTANT**

All individuals receiving health benefits under employee welfare benefit plans have an interest in the question presented by this case. If health benefit coverage is terminated improperly during the course of treatment, their health could be put at risk. Indeed, their lives could be at risk.

Amicus is concerned that the Fourth Circuit's ruling could jeopardize potentially life-saving treatment for patients in situations where coverage is terminated during the course of treatment. As an example, many patients need extended hospitalization for various forms of medical or psychiatric treatment. Imagine a patient who has been admitted for inpatient treatment. The admission has been approved by the health plan administrator, so treatment begins. If, however, the plan then decides to terminate coverage while the patient is hospitalized, the patient's health is put at risk at a time when the patient is least able to challenge the denial.

Using Petitioner Gagliano's case as an example, if the health treatment coverage is terminated because, following hospital admission, the plan determines that the claim should not have

been approved because of a pre-existing condition, and if the plan then refuses to pay for further care without notifying the patient of a denial in a manner that complies 29 U.S.C. § 1133 and procedural regulations at 29 C.F.R. § 2560.503-1, the patient then faces substantial risk. Where health benefits are terminated by a plan administrator without complying with the patient's procedural safeguards, the patient should be allowed to have health benefits continue to be paid until the plan administrator complies with ERISA's procedural protections. As the Fourth Circuit has noted, "These procedural guidelines are at the foundation of ERISA." *Weaver v. Phoenix Home Life Mut. Ins. Co.*, 990 F.2d 154, 157 (CA4 1993).

## II. THE CIRCUITS ARE DIVIDED OVER THE QUESTION PRESENTED

As noted by Petitioner, the Fourth Circuit decision below conflicts with the Third, Sixth, Seventh, and Ninth Circuits. The Fourth Circuit expressly acknowledged that it was creating a circuit split. Pet. App. 22a ("The district court's reliance on the Sixth Circuit's decision in *Wenner*<sup>3</sup> was misplaced, both because it is contrary to the law of this circuit and because that decision's rationale is flawed."). In *Wenner*, the Sixth Circuit held that a court may reinstate benefits that have been terminated in violation of 29 U.S.C. § 1133.

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<sup>3</sup> *Wenner v. Sun Life Assurance Co.*, 482 F.3d 878, 883 (CA6 2007).

The Sixth Circuit holding in *Wenner* is consistent with the Seventh Circuit holding in *Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3d 621 (CA7 2005); the Third Circuit holding in *Grossmuller v. Int'l. Union et al.*, 715 F.2d 853 (CA3 1983); and the Ninth Circuit holding in *Pannebecker v. Liberty Life Assurance Co.*, 542 F.3d 1213, 1221 (CA9 2008).

### CONCLUSION

For the reasons discussed above, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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